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# IMJ

*Illinois Medical Journal*

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

January, 1971

Vol. 139/No. 1

Contents page 3

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REC'D

CIRCULARS

**hmo?  
fmc?**  
SEE PAGE 50

**ekg  
of the  
month  
new feature**  
SEE PAGE 47

**diphtheria**  
SEE PAGE 35

# When the stage is set for diarrhea...

## Diarrhea . . . thwarted once again!

Time after time . . . just when plans seem sure to be shattered . . . the effective and prompt action of Lomotil comes to the rescue.

Here is an antidiarrheal with a performance record that few can challenge. A versatile actor, Lomotil stars in the treatment of diarrhea associated with gastroenteritis, irritable bowel, functional hypermotility, regional enteritis, malabsorption syndrome, drugs, acute infections, ulcerative colitis and food poisoning. In addition, it plays a major role in the control of intestinal transit time in patients with ileostomies and colostomies and of the diarrhea occurring after gastric surgery.

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# Lomotil<sup>®</sup>

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Each tablet and each 5 cc. of liquid contain:

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(Warning: may be habit-forming)

Atropine sulfate . . . . . 0.025 mg.

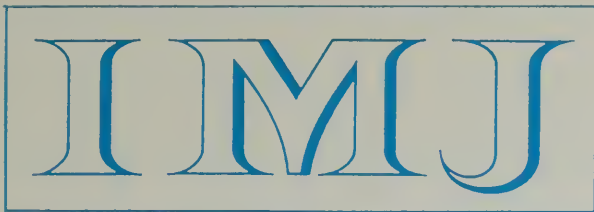
## Saves the Show



**Warnings:** Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

**Precautions:** Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be





illinois  
medical journal

volume 139, number 1

January, 1971

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clinical articles	Diphtheria in Chicago, 1960-1970 .....	35
	<i>Kenrad E. Nelson, M.D., Charles A. Kallick, M.D., and Stuart Levin, M.D.</i>	
	The hypochondriacal patient in the physician's office .....	66
	<i>John Cowen, M.B., Ch.B., D.P.M.</i>	

surgical grand rounds	Toxic megacolon .....	41
special articles	hmo or fmc? Drastic changes ahead in medical care .....	50
	Leadership Conference abstracts: "Health Care Delivery Changes in the 70s" .....	53

features	Blue Shield Report .....	9
	the president's page .....	26
	the view box .....	40
	ekg of the month .....	47
	membership forum .....	48
	the doctors library .....	49
	practice management .....	70
	medical legal review .....	71
	public affairs .....	72
	new pharmaceutical specialties .....	74
	editorials .....	75
	socio-economic news .....	83
	continuing education news .....	87
	imaa report .....	92
	clinics for crippled children .....	94
	obituaries .....	94

(Cover story on page 17)

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**When Cerebrovascular Disturbances occur.**





# BLUE SHIELD REPORT



## FOR *Illinois Physicians*



### Dr. Bornemeier Delivers Speech to AMA Convention

American Medical Association president Walter C. Bornemeier, M.D., (above) delivered his report to the opening session of the House of Delegates at the Clinical Convention Nov. 29 in Boston.

Dr. Bornemeier, of Chicago, has served as a trustee of Illinois Medical Service since 1953.

In his address, he called for "forward-looking solutions" to health care problems including the need for more high quality physicians. He also recommended that, as much as possible, health problems be taken care of "outside the costly confines of today's hospital."

### COORDINATION OF BENEFITS: Keeping Down the Cost

As health care costs continue to rise, there has been increasing pressure on Blue Shield to impose additional types of cost controls.

One such control now being written into many of our contracts is known as "Coordination of Benefits." This control stipulates that when a patient is covered by more than one insurance company, benefits will be provided to cover the cost of the hospital and medical bills, but not allow the patient to "profit" from his misfortune.

### American Hospital Supply Buys National Blue Shield

The American Hospital Supply Corporation has purchased national Blue Shield coverage. This means it becomes one of our national groups (described in the August 1970 and September 1968 *Blue Shield Report*) and subscribers will carry with them the new national identification card (see below).

If your patient has a national identification card, fill out the Physician's Service Report in the usual manner and send it to us, Illinois Medical Service, even if the subscriber is from out-of-state.

Use the "Member Identification" letter and number combination as you would the group and subscriber number. For example, in the card shown, "AHS 121" is the group number and "234-56-6789" is the subscriber number (and also his social security number).

<b>BLUE CROSS·BLUE SHIELD</b>		
<b>IDENTIFICATION CARD</b>		
<b>AMERICAN HOSPITAL SUPPLY CORPORATION</b>		
		<b>PLAN CODE</b> 121
<b>NAME</b>		
SEAMAN R. V.		
<b>MEMBER IDENTIFICATION</b>		
AHS121-243-56-6789		

It is simple logic that when it becomes *profitable* to be hospitalized or receive medical care, that utilization of benefits will be increased, resulting in the rising cost of medical care and ultimately in an increase in Blue Shield premium rates.

The technicalities of percentage of reimbursement by Blue Shield and any other insurance company which covers a beneficiary will be worked out between the carriers. But in no case will the total payments exceed the hospital or medical bills incurred by the member.

(This is not an advertisement)

## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

#### Coverage of Automated Laboratory Tests

The total charge for an initial automated battery of tests, if one or more of the tests are required, will be paid by Medicare under new regulations issued by the Social Security Administration.

When a battery of tests is repeated, however, only those individual tests in the battery which are required to follow the patient's progress are covered. In no event, however, will payment for the covered tests exceed the reasonable charge for the battery.

As before, tests are covered under Medicare if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. Routine tests are excluded. Thus, where no tests in an automated battery of tests performed can be reasonably related to a specific complaint or symptom, no payment will be allowed for the battery.

#### PORTABLE X-RAY BENEFITS AND EXCLUSIONS

Under a new Medicare revision, Medicare benefits for portable X-ray services not under the direct supervision of a physician remain the same:

1. Skeletal films involving the extremities (the arms and legs), pelvis, vertebral column and skull.
2. Chest films which do not involve the use of contrast media.
3. Abdominal films which do not involve the use of contrast media.

However, the Social Security Administration has enumerated the exclusions from coverage. They include:

1. Procedure involving fluoroscopy.
2. Procedures involving the use of contrast media.
3. Procedures requiring the administration of a substance to the patient or injection of a substance into the patient and/or special manipulation of the patient.
4. Procedures which require special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which require that medical judgement be exercised.
5. Routine screening procedures.
6. Procedures which are not of a diagnostic nature.

## NEW RULES FOR NURSING HOME VISITS

The Social Security Administration has announced additional regulations regarding Medicare payments when physicians treat patients in a nursing home.

According to the new regulations, Medicare payments can be made for only *one* patient visit to the same patient in a nursing home in a calendar month. Payment for additional visits for a specific patient will be made only when the physician substantiates the medical necessity for more than one visit.

When only one patient is visited, payment will not exceed the maximum allowance for a routine follow-up house call. Also, no additional charge for travel will be paid except in "extraordinary circumstances."

Visits scheduled by the physician to *all* his patients in a home once per month would be allowable. However, when more than one patient is seen in a nursing home, payments will not exceed the customary charge for routine follow-up office visits.

Unless otherwise indicated on the Medicare claim or itemized statement, the Part B Medicare Carrier has to assume that a claim for a visit to a nursing home included more than one patient and will make payment on that basis.

When completing a claim form or itemized statement, the Social Security Administration suggests that you indicate "only patient seen" or "special visit—acute" when applicable. This information will help us make payments correctly and promptly.

For additional information contact your Professional Relations Representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois, 60601.

#### Exclusions in Medicare Coverage

The Social Security Administration has defined physicians' services to mean the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery and consultation. However, telephone calls (including those in which the physician provides advice or instructions) and visits for the *sole* purpose of obtaining or renewing a prescription, the need for which was previously determined—so that no examination of the patient is performed—are not covered services.





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### COVER STORY

The January issue of the IMJ in keeping with the tradition of "new year's resolutions" has made same of its own—both typographically and editorially.

New mastheads for features have been chosen for continuity and highlight purposes. In addition, four new features, "invest corner," "medical legal review," "practice management" and "ekg of the month" have been added.

In order to keep physicians abreast of happenings on the medical scene, the *Journal* has expanded its coverage of legislative affairs and ISMS committee and council news.



The negative power of anxiety...

This man thinks he may  
never work again.





The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

#### How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler<sup>1</sup> reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.<sup>1</sup>

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,<sup>2</sup> who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

**Relief of anxiety with Librium®** (chlordiazepoxide HCl) often proves a valuable adjunct to medical counsel, reassurance and the total management program; may help prevent the postcoronary patient from regressing into a state of invalidism.

As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl): Quickly relieves anxiety of mild to severe degree in most cases. Helps expedite cooperation in therapeutic regimen. May be used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents

and diuretics. By relieving anxiety, helps encourage productive activities. Has a wide margin of safety and, in proper maintenance dosage, seldom impairs mental acuity or ability to function. Often effective in extended therapy, usually without diminution of effect or need for increase in dosage—in protracted use, periodic blood counts and liver function tests are advisable.

**References:** 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

To curb anxiety in the postcoronary patient adjunctive

**Librium®**  
(chlordiazepoxide HCl)  
10-mg capsules

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Nutley, New Jersey 07110



## Catastrophic Death Toll in 1969

The catastrophic death toll in 1969, was somewhat over 1,300—about the same as in 1968, but below the annual average for the past decade in the United States (excluding Alaska and Hawaii), according to statisticians of Metropolitan Life Insurance Company.

During 1969, there were eight major catastrophes, (a catastrophe is a disaster claiming 25 or more lives); in the aggregate they resulted in 542 deaths. Five of these disasters were natural catastrophes, the largest occurring on August 17 when a hurricane swept through Mississippi and Louisiana killing about 200 persons. The four other natural disasters were the hurricane caused flood which occurred in Virginia on August 20, taking 80 lives; the rain, floods, and subsequent mud slides in California late in January, causing 43 deaths; the tornadoes in northern Ohio on July 4, which killed 41; and the tornadoes which struck southern Mississippi on January 23, fatally injuring 32 persons.

Two of the disasters involved accidents in civil aviation: the collision of a scheduled plane and a small private airplane on September 9, near Indianapolis, Ind., which took 83 lives; and the crash of a scheduled plane into the Pacific near Los Angeles, Cal., on January 18, taking 38 lives. The other major catastrophe involved the collision of an oil barge and a freighter near New Orleans, La., on April 6, resulting in the loss of 25 lives.

Most of the types of catastrophes—fires and explosions, motor vehicle, civil aviation, mines and quarries—were responsible for fewer deaths in 1969, than in 1968. However, the number fatally injured in natural catastrophes rose sharply, while deaths in military aviation increased slightly.

Metropolitan statisticians point out that natural accidents—hurricanes, floods, tornadoes, etc.—accounted for one-third of the catastrophic deaths in 1969. Fires and explosions (mostly in private homes and apartments) and civil aviation each caused about one-fifth of the total loss of life. Motor vehicle accidents were responsible for one-sixth of all catastrophic fatalities, with military aviation contributing to the majority of the remainder.

**Brief Summary of Prescribing Information—**9-9/22/69. For complete information consult Official Package Circular.

**Indications:** Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

**Contraindications:** Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

**Warnings:** Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

**Precautions:** Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or *bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being pre-diabetic should be kept under close observation if treated with this agent.

**Adverse Reactions:** Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

**Usual Dose:** 1 tablet b.i.d.

**Supplied:** Bottles of 60, 600, and 1000 scored 50 mg. tablets.

# Salutensin®

hydroflumethiazide, 50 mg./reserpine,  
0.125 mg. protoveratrine A, 0.2 mg.

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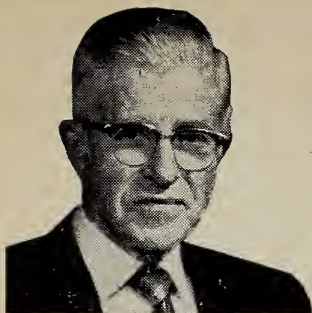
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# the presidents page

## *Is group practice*

Our biggest health care delivery problem today is to provide quality care at a reasonable cost to an ever-expanding population . . . a population clamoring for more and more services.

The shortage of physicians along with the substantial investment in time and money required for medical education compounds the problem. It is evident that if we are to cope with the crisis in health care, we must increase the supply of all medical personnel, and use a delivery system which makes the most efficient use of our time and talents.

The shortage . . . and maldistribution . . . of physicians is all too real. For every 100,000 Illinois residents in 1967, we had only 94 practicing physicians. This compares to a national average of 102 physicians for 100,000 persons. In New York the ratio was 136, and in California, 134 for each 100,000 persons. We also note that while two-thirds of Illinois physicians practice in Cook County, only one-half of the state's population live in Cook County. This means that only one-third of our physicians are available to treat the remaining one-half of our population.

The backbone of medical care in our state—particularly outside Cook County—is the generalist, the family doctor who provides quality care at a reasonable cost. His greatest reward lies in the respect and gratitude of his patients. However, his life is a hard one. His hours are long, the demands by patients and associates hard to fulfill and his material remuneration far less than deserved. Many of these generalists are over 50 years of age and when they die or retire very few of them are replaced. With little success ISMS has for years exerted great effort to increase the number of general practitioners and urge those graduating to go to smaller towns to practice.

## *the answer?*

Last spring we asked 5,000 students, residents and interns in Illinois about their future plans in medicine. To our dismay we learned that they were planning to do just what their recent predecessors had done. Over 15% do not plan to practice medicine at all; only about 7% plan to go into general practice, while the vast majority plan to specialize. Even more disheartening, only 30% plan to stay in Illinois and of these, only 1/3 plan to practice outside of Cook County. It is evident that we Illinois physicians, who live in one of the most wealthy states in the nation, must utilize more allied health personnel and efficient business methods if we are to fulfill our responsibility to society.

The solo practitioner is often hard put to employ additional personnel, lease a computer and provide expert care in all special areas. His salvation may lie in joining with other physicians to provide high quality service to more people than he now serves. This, then, is the logic behind the recommendation that physicians form "group practice." Their association may be very loose or very tight, as individuals working in separate offices within the confines of a clinic type building, or legally bound together in a tight relationship as a partnership, in a foundation or in a corporate structure sharing patients, facilities, expenses and income.

In the survey, 92% of interns and 98% of residents said they plan to specialize. Eighty per cent said they would join a group, so it is obvious we will get very few young doctors unless we can offer them group associations. It is clear that if the people of our state, particularly outside Cook County, are to obtain medical services it must be done by doctors working in groups with adequate allied medical personnel assisting. Throughout the country the profession is rapidly



turning to the formation of groups, as evidenced by a four-fold increase in the number of groups in the past ten years and the fact that about 15% of all practicing physicians are now in groups. An AMA survey disclosed that multiple specialty groups are most popular. Although they make up only 38% of the total number of groups, they contain 61% of the physicians.

I firmly believe that the very best medical care is provided by the experienced and well-trained generalist. Not only is he capable of diagnosing and treating most common diseases, but he will also refer his patient to the specialist he considers most competent. In addition, he has empathy and affection for his people and provides understanding and moral support that few specialists are capable of providing. The care supplied by the generalist is not only better but less expensive, as demonstrated by the difference between the cost of a visit to his office and to the hospital emergency room.

However, since generalists are not going to be available in quantity, we must embrace other methods of providing medical care to the people. I think the logical alternative is group practice. I also believe that if we physicians do not provide groups someone else will. The federal government, with its HMO plan, makes it possible for any not-for-profit organization to hire physicians and do the job for us.

For quality medical care it is obvious the group practice units must be owned and controlled by physicians who preserve the traditional freedoms of medicine. Group practice units owned by a "not-for-profit" organization legally may hire physicians and deliver medical care, but their primary concern is *money* not quality medical care. The physician-owned groups, however, do emphasize quality care. The patient also has freedom of choice in selecting his physician, a freedom he must surrender under the lay controlled group. The physician is stimulated to do a good job since he wants to retain the patient and his respect.

There are two organizations of group practice units—the American Association of Medical Clinics and the Group Health Association of America Incorporated. The American Association of Medical Clinics is a voluntary association of physician-controlled medical centers which provide medical care in their communities by means of the private group practice of medicine. The groups range from five doctors to several hundred, and they include such clinics as Mayo's and the Cleveland Clinic. They provide care for more than 12 million Americans.

The other organization, the Group Health Association of America Incorporated, is an association of closed panel group practice units owned and operated by different not-for-profit organizations such as HIP in New York and Kaiser-Permanente in California. John G. Venimen, Undersecretary of HEW, who proposed the health maintenance organizations, stated specifically that HIP and Kaiser-Permanente would qualify and that *medical costs* could be controlled. The Group Health Association of America has strongly supported the Griffiths Bill before Congress, which is the AFL-CIO bill and provides federal financing of medical care for all.

Most groups have some generalists who have the personality to provide the personal touch. Some groups assign the new patients to the internists who serve as the "family" doctors. Unless the patient asks for a specific physician, one clinic in New England assigns all new patients to the physicians in rotation. The assigned doctor then becomes the patient's personal physician, takes the history and does the physical examination. This then would be "his" patient and even though she/he were seen by several others in the clinic she/he would come back to him for the explanation of the diagnosis and for empathy. This plan works two ways. Not only does the patient have a personal physician but the specialist physician is kept in practice taking histories and doing physicals.

I am much concerned when I hear that some of the hospitals in this state are considering hiring doctors and operating "closed panel" group practice units.

Members of ISMS, it is later than you think. We must improve methods of health care delivery. If we don't, we may one day find ourselves on a "closed panel" payroll and told to practice as the management dictates.

To preserve the traditional quality and freedom of American medicine, we physicians must remain in control of health care delivery. Maintaining quality care for our patients has always been, and must always be our major concern. We must not allow laymen to make us little more than health mechanics on a medical care assembly line. For us there must be no overtime for after-hours appendectomies, or double time for Sunday surgery.

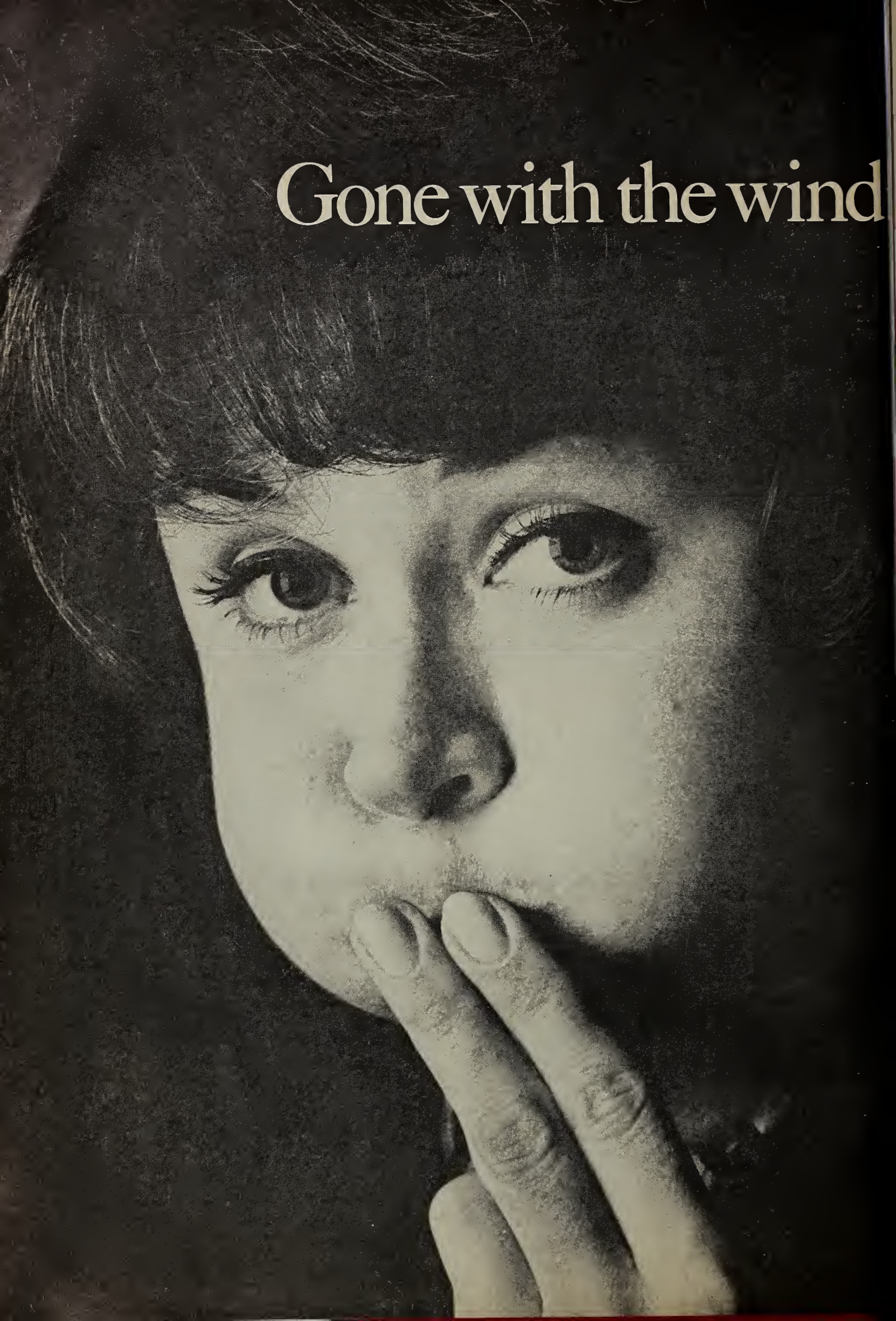
In closing, let me quote a statement from the latest American College of Radiology Bulletin on the plight of physicians in Quebec, who are soon to be subjected to socialized medicine:

"As soon as the Quebec premier declares the

*(Continued on page 28)*



Gone with the wind







IIMJ  
*Illinois Medical Journal*

# Diphtheria in Chicago 1960-1970

BY KENRAD E. NELSON, M.D., CHARLES A. KALLICK, M.D., AND  
STUART LEVIN, M.D./CHICAGO

A substantial increase in the number of reported cases of diphtheria has occurred in Chicago in 1970. In addition, sizable outbreaks of diphtheria have been reported recently from San Antonio, and Austin, Texas, Miami, Florida, and Phoenix, Arizona.<sup>1-6</sup> During the past five years, the United States has experienced an interruption in the progressive downward trend in incidence that began in 1920. While diphtheria does not presently constitute a major epidemic problem, the continued occurrence of cases and periodic outbreaks at a steady or slightly increasing rate is disturbing. In an effort to understand the nature of the present diphtheria problem in Chicago, we have reviewed the epidemiological features of the cases reported in Chicago, and the clinical features of the cases treated at the Municipal Contagious Disease Hospital in the interval 1960 through November 30, 1970.

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Stuart Levin, M.D., is chief of the Infectious Diseases Section at Rush-Presbyterian St. Luke's Medical Center, Chicago, and assistant professor of medicine at the University of Illinois College of Medicine.

## Material

The clinical data upon which this report is based include all of the cases or asymptomatic carriers of the diphtheria bacillus admitted to the Chicago Municipal Contagious Disease Hospital (M.C.D.H.). Cases were defined as those patients with the clinical features of diphtheria from whom a culture for *C. Diphtheriae* from the respiratory tract was obtained. Carriers had no history or symptomatology of infection but had a positive culture. (For purposes of this discussion, either cases or carriers may be referred to as infections or infected patients.) In addition, certain epidemiological features of all the cases reported in Chicago, including some patients who were not seen at M.C.D.H., were analyzed in order to gain a more complete understanding of the nature of the diphtheria problem in Chicago during this decade.

## Results

All of the diphtheria cases and deaths reported from Illinois, including those from downstate Illinois, Chicago and those seen at M.C.D.H. are shown by year. (Table 1) Most of the cases were reported from downstate Illinois between 1960 and 1962. Since 1963, however, more of the cases were reported from Chicago.

**Table 1**

**Diphtheria Cases and Deaths by Year, 1960-1970.\* Adjusted Totals for Illinois and Chicago and Municipal Contagious Disease Hospital (M.C.D.H.) in Chicago.**

Year	Chicago	M.C.D.H.	Other Illinois	Total
1960	2	2	8(1)	10(1)
1961	1	1	9	10
1962	4(1)	3	2	6(1)
1963	13(2)	12(2)	6(1)	19(3)
1964	8(2)	5	1	9(2)
1965	2	1	1	3
1966	2(1)	2(1)	1	3(1)
1967	4(2)	1	1	5(2)
1968	2	2	1	3
1969	1(1)	0	1	2(1)
1970	23(1)	9	0	23(1)
	62(10)	38(3)	31(2)	93(12)

\*Deaths are listed in parenthesis: figures for 1970 include reported cases as of November 30, 1970.

The Chicago cases in 1963, 1964 and 1970 do not represent single large outbreaks. Instead, several small clusters of cases not directly re-

*From the Board of Health, Municipal Contagious Disease Hospital, Department of Preventive Medicine and Community Health, Pediatrics and Medicine, University of Illinois Medical School, and Rush-Presbyterian St. Luke's Medical Center.*

lated to one another occurred during these years of high incidence. During the period of this study, a total of 33 small outbreaks of symptomatic infections or asymptomatic carriers involving from one to eight people each were identified among the admissions to M.C.D.H. and their contacts. (Table 2) These outbreaks involved a total of 81 people, of whom 62 were hospitalized at M.C.D.H.

**Table 2**

**Diphtheria outbreaks by number of persons involved (when at least one of the cases in each outbreak was cared for at Municipal Contagious Disease Hospital in Chicago) 1960-1970.\***

Number persons	Outbreaks		(Death rate)
	Number	Number with a death	
1	13	1	(7.7%)
2	9	5	(27.7%)
3	4	0	
4	4	1	(25.0%)
7	2	1	(7.1%)
8	1	1	(12.5%)
	33	9	

\*Data include cases and carriers, of the 81 persons infected in the course of these outbreaks 62 were hospitalized at M.C.D.H. and the remainder were seen elsewhere or were not diagnosed and treated. The figures in this table are for the period 1960-November 30, 1970.

The case fatality ratio was 7.9% among the cases treated at M.C.D.H. and 29.1% among the cases reported from other Chicago hospitals for a total Chicago mortality ratio of 16.1%. The case fatality ratio from downstate Illinois was 6.4%. In several instances the first case in a small outbreak was seen in a general hospital in Chicago and diphtheria was not seriously considered. When severe disease or death occurred, the related cases were hospitalized at M.C.D.H. and promptly treated with antitoxin.

It has been our policy to immediately examine and culture each household member or other close contact of a diphtheria case as soon as the diagnosis has been made. Also household visits are made on all reported cases by public health nurses from the Chicago Board of Health to detect other important contacts who might be infected or be at risk to diphtheria. Unfortunately, the initial case detected in an outbreak often has ended fatally. Fatalities were associated with nine (27.3%) of the 33 outbreaks in our series.

The immunization status of the patients seen at M.C.D.H. is shown in Table 3. Only seven



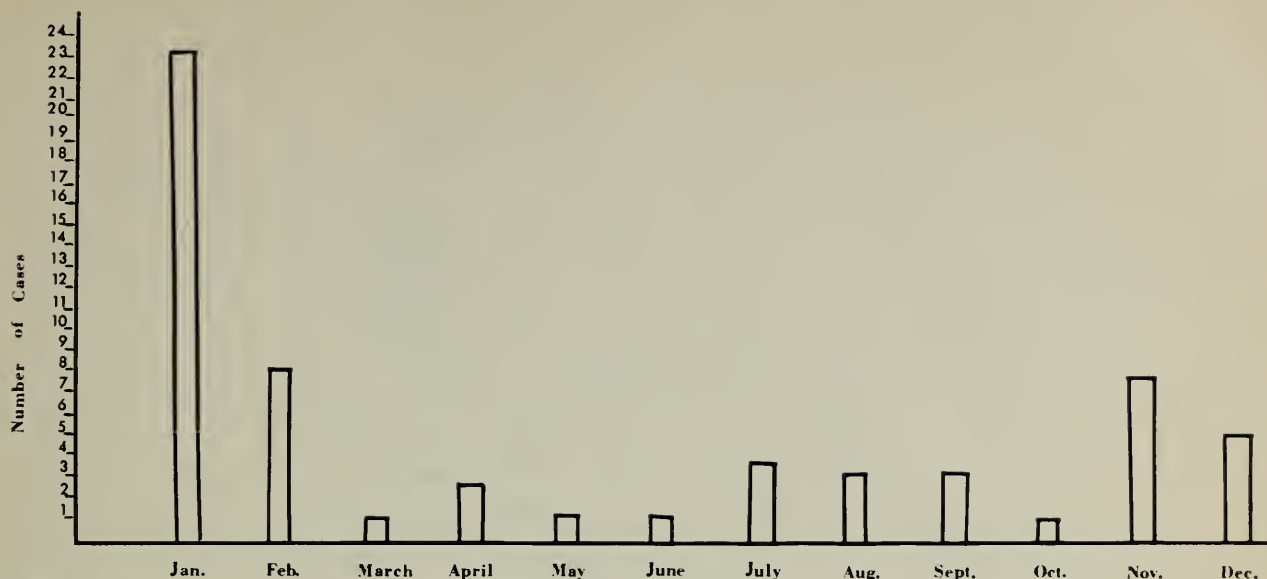


Fig. 1

(18.4%) of the 38 cases had histories of complete DPT immunization. However, one of the three fatal cases had been completely immunized. In contrast 14 (60.8%) of the 23 carriers detected as a part of an investigation of an outbreak (defined as "outbreak carriers") had complete DPT immunization. An additional 14 carriers were referred to M.C.D.H. for treatment of a diphtheria carrier state that had been detected on a routine throat culture, usually as a part of a pre-employment health evaluation for a "high-risk" occupation such as a hospital or nursing home worker. These were defined as "endemic carriers." Only one of this latter group of 14 persons had never received DPT immunizations and nine (64.4%) had been completely immunized.

Most of the reported cases, and the carriers associated with outbreaks were children or adolescents. (Table 4) In distinct contrast, the endemic carriers were often older adults. The age of this latter group ranged between 10 and 63 years with a median age of 24 years. The median age of the cases was six years and only five (7.8%) of the reported cases were over 18 years of age.

More cases were reported during the late fall and winter months, November-February, than at other times in the year. However, cases occurred during every month. (Fig. 1)

One of the striking features, of the reported diphtheria infections in Chicago has been its geographic distribution within the city. (Fig. 2) The rates were highest on the North Side of the city (45.5/1,000,000 persons)\*, next highest on the West Side (34.3/1,000,000 persons)\*, and

Table 3

Immunization status and clinical classification of persons infected with diphtheria bacillus who were treated at Municipal Contagious Disease Hospital in Chicago, 1960-1970.\*

Immunizations status	Clinical Category		
	Cases	"Outbreak carriers"*	"Endemic carriers"*
Complete +	8	14	9
Incomplete	9	0	1
Indeterminate	6	4	3
None	15	5	1
	38	23	14

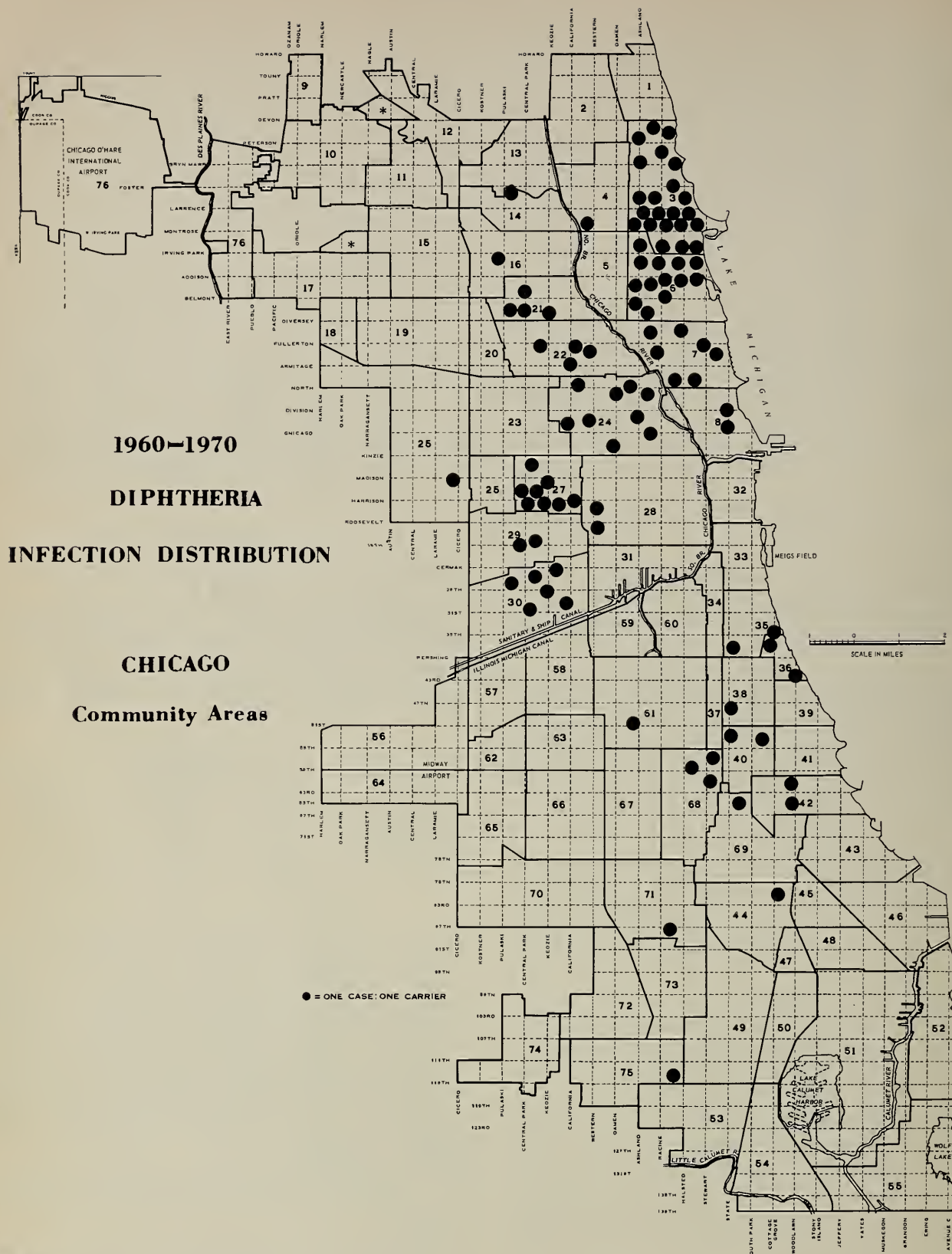
\* Figures in this table include all persons treated between 1960 and November 30 1970. "Outbreak Carriers" is defined as a person detected as a carrier during an investigation of an outbreak, i.e., in connection with at least one clinical case. "Endemic Carrier" is defined as a person detected as a carrier during a routine, usual pre-employment, culture.

+ Complete immunization is defined as at least three doses of diphtheria toxoid. Incomplete immunization as/or two doses of toxoid and indeterminate as those persons in whom the immunization history could not be ascertained.

least on the South Side (11.6/1,000,000 persons)\*. (Fig. 3)

Furthermore, the incidence of reported infections was comparatively much higher in community area three (Uptown) than in other areas of the city. The rates in Uptown were about 1 per 5,000 persons during this nearly 11 year in-

\*The population figures used as a denominator for these calculations were those of the 1960 census.



**Fig. 2**

interval. The next highest infection rates were experienced by community area 21 (Avondale) on the North Side and Community Area 27 (East Garfield Park) on the West Side. The largest single outbreak during the period of this study

occurred in East Garfield Park. The two North Side Community areas, on the other hand, were consistently the foci of sporadic infections and small outbreaks during the past decade.

Among the 78 patients seen at M.C.D.H., 35



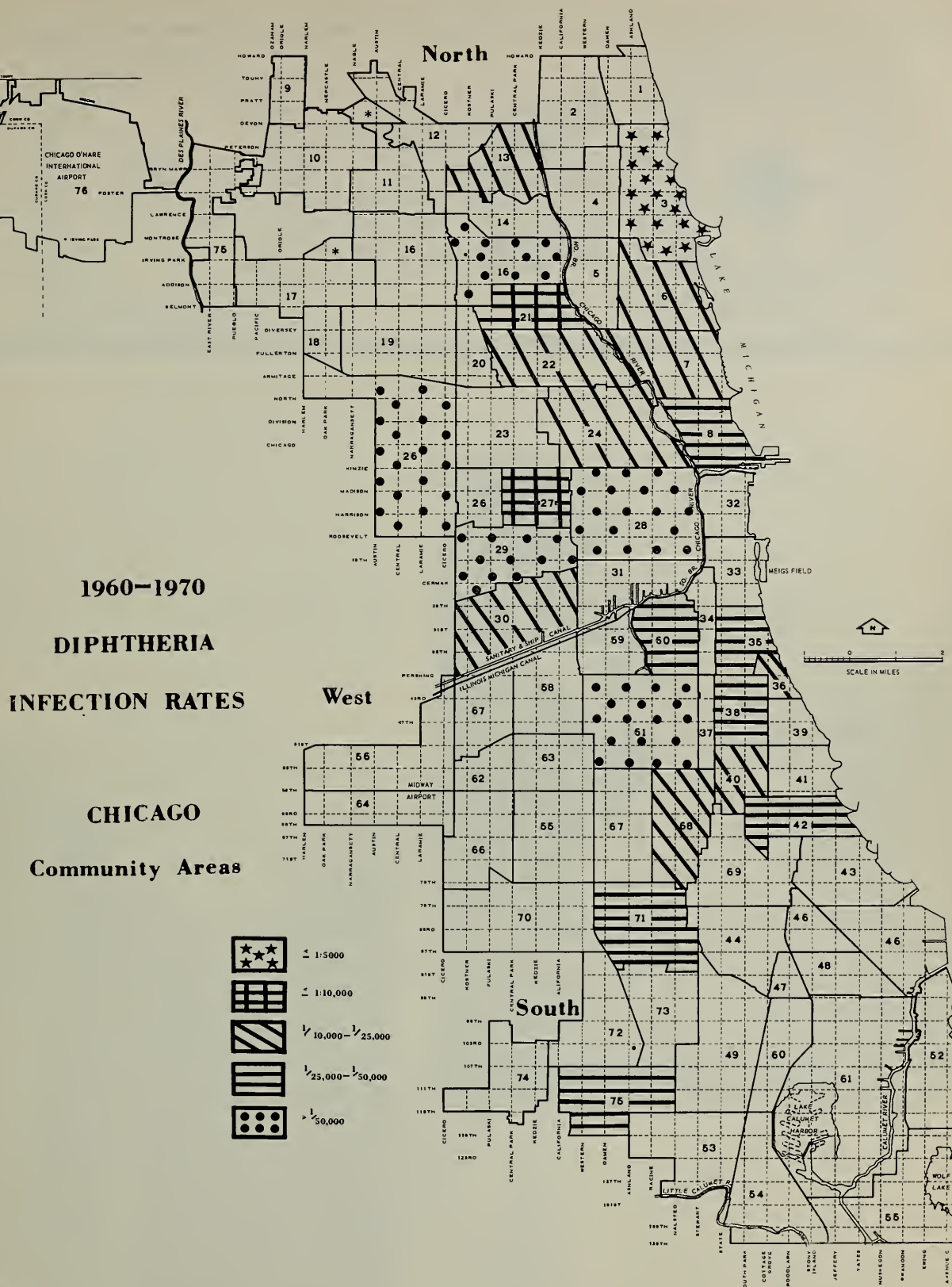
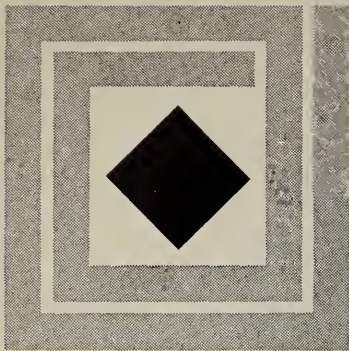


Fig. 3

(44.9%) were born outside of Chicago, twenty-eight of these patients born outside of Chicago were from the Southern United States or Puerto Rico. However, most of these patients had been living in Chicago for a year or more prior to

the diagnosis of their infection.

When the analysis by place of birth was expanded to include the place of birth of the parents of the diphtheria patients, the results were (Continued on page 77)



# the view box

By LEON LOVE, M.D./DIRECTOR AND CHAIRMAN, DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



**Fig. 1**

This patient was a 2½-year-old girl admitted to the hospital because of a four week history of an unexplained fever and a gradually enlarging mass in the right upper quadrant. Physical examination revealed a rather hard mass in the right upper quadrant of the abdomen. The patient's blood pressure was 160/90. What's your diagnosis?

1. Pheochromocytoma
2. Neuroblastoma
3. Wilm's Tumor
4. Leukemia

(Answer on page 96)



**Fig. 2**





## surgical grand rounds

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant Memorial, Chicago Wesley Memorial, and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds on April 4, 1970.*

# Toxic megacolon

EDITED BY JOHN M. BEAL, M.D.,/CHICAGO



**Fig. 1.** Plain film of abdomen demonstrates dilation of colon with irregularity of mucosal surface.

## Case Report:

**Dr. Maurice Schulten:** A 47-year-old married, white female was admitted to Passavant Memorial Hospital March 17, 1970 with a one week history of watery stools, 8 to 10 per day, associated with lower abdominal cramping pain, anorexia and a 15 pound weight loss. Four days before admission, one cup of fresh blood followed each of her diarrheal stools. During the early part of this episode, she took paregoric and Polymagma, neither of which controlled the diarrhea. She denied nausea, vomiting, syncope, fever, chills or hematemesis, or other gastrointestinal symptoms prior to the onset of the present illness. She denied travel to foreign countries. She had a 26 year history of ankylosing spondylitis for which she took Butazolidin. A history of allergies was not given. There is a strong family history of diabetes mellitus. A review of systems was not remarkable.

Physical examination: blood pressure, 120/82; pulse, 94 and regular; respirations, 24; temperature, 98°. The patient was well developed, dehydrated, anxious and not in apparent acute distress when admitted. Significant physical findings included dry membranes of the oral cavity, a grade II systolic heart murmur along the left

sternal border, a moderately distended, diffusely tender abdomen without localized tenderness. Tympany was present in all quadrants. Organs or masses were not felt and bowel sounds were hypoactive. Rectal examination yielded black stool on the glove. Examination of the back showed a bamboo straight back with limitation of motion consistent with ankylosing spondylitis. Neurological examination and extremities were essentially normal.

Admission laboratory values: hemoglobin, 14 gm.; hematocrit, 42%; white blood count, 19,500 with 72 segmented neutrophils and 10 bands. Fasting blood sugar, 100; BUN, 6. Urinalysis and serum electrolytes were normal. Routine stool cultures and examination of the stool for ova and parasites were unremarkable. A proctoscopy was performed March 18, and the biopsy was reported to demonstrate chronic inflammation.

**Dr. Earl Nudelman:** Films taken March 22, show rather generalized distention of the colon, but most marked involving the transverse colon. (Fig. 1). The wall of the transverse colon is thickened and there is irregularity of the mucosal surface, better seen on the decubitus film, and some areas of narrowing. There was irregularity of the colon wall and thickening on the supine film. Plain films two days later show a little more increase in the distention of the transverse colon relative to the remainder of the colon. On all of the films, there is considerable small bowel distention; however, there are no air fluid levels present and presumably this is due to a relative incompetency of the ileocecal valve.

This is an interesting case, not only from the standpoint of surgery, but from the standpoint of radiology. The initial two sets of plain films of the abdomen certainly would have been consistent with a diagnosis of toxic dilatation or megacolon secondary to ulcerative colitis. The barium enema, which was performed the day after admission, is suggestive of granulomatous colitis. (Fig. 2) The reason is that the rectum appears to be relatively normal. Large marginal pseudopolyps certainly can be seen in both ulcerative colitis and ulcerative granulomatous colitis, but the larger, smoother polyps or pseudopolyps seen



**Fig. 2.** Barium enema shows extensive disease, involving most of the colon.



in this case are more characteristic of granulomatous colitis. The evacuation film was striking in that longitudinal ulcerations were detected which again are often described as being seen with granulomatous colitis, and not being seen with ulcerative colitis. Transverse fissuring is not quite as striking as one expects to see with granulomatous colitis, and that would lean one toward the diagnosis of ulcerative colitis. There are no definite skip areas, except for the fact that the rectum and sigmoid look relatively normal. It has been said that radiologists are supposed to be able to tell easily the difference between granulomatous and ulcerative colitis. However, it has

operating room, where a total colectomy and ileostomy were performed. The postoperative course was complicated by a psychotic episode and by a wound infection.

**Dr. Joseph Sherrick:** Examination of the biopsy, done six days before colectomy, revealed a few chronic inflammatory cells in the submucosa and muscularis mucosa. In one area, there was an incipient microabscess which was still covered by mucosa. At the time, our diagnosis was chronic inflammation of the colon. A week later, we received the entire colon including the anus, and a segment of ileum. Figure 3 shows the extent of the process with ulcers involving at



**Fig. 3.** Photograph of mucosal surface of colon, showing dark color and extensive ulceration.

been our experience that this often is a very difficult diagnosis to make radiographically. When you see the patients with fairly extensive disease, as this patient certainly has, the differentiation between the two entities is much more difficult than if you have an early, classic case.

**Dr. Schulten:** Steroid therapy was initiated. On March 23, she was found to be markedly distended. A Foley catheter and rectal tube were inserted and the patient improved. That night the patient again began having bloody stools. The following morning, her hemoglobin was 11.1, the hematocrit 36, and the white blood count 26,700 with 73 segs and 7 bands. The following evening the patient was taken to the

least 50% of the mucosa of the colon, exposing the submucosa. A section through the edge of one of these ulcers (Fig. 4) shows the mucosa entirely denuded with the base of the ulcer composed of inflammatory granulation tissue. This is a characteristic, extensive crypt ulcer or microabscess of the type seen in chronic ulcerative colitis. In some areas, the entire thickness of the wall was destroyed, and replaced by granulation tissue extending clear out to the serosa. At least one area of perforation was noted. Crypt abscesses were present clear down to the anus. An interesting feature was the presence of fresh fibrin thrombi in some of the mesenteric vessels. (Fig. 5) Whether this is the cause of the extensive necrosis or the result is not known, but





**Fig. 4.** Photograph of section of colon, edge of an extensive crypt ulcer.

ischemia might be a contributing factor in necrosis and perforation. The segment of ileum was relatively spared except for beginning peritonitis.

**Dr. Schulten:** When the operation was performed and the peritoneal cavity was opened, a small, pin-hole perforation was found in the cecum which evidently had occurred a short time before operation.

**Dr. Thomas Haas:** Although the association of a dilatation of the colon with systemic manifestations of an inflammatory process had been known for a long period of time, it was in 1950 that the disease process was named toxic megacolon by R. H. Marshak. The incidence of this disease is uncertain. The incidence is reported to be increasing from previous records in the 1950's of 1 to 2% of ulcerative colitis patients to approximately 4% at present. There is reason for this apparent increase. One is the disassociation of granulomatous colitis as a clinicopathologic entity. Second, the increased knowledge of the disease accounts for an apparent increase. The tendency for patients with the disease to gravitate to medical centers with special inter-

est in ulcerative colitis further tends to expand the experience.

There is no sex predilection for toxic megacolon. It affects females as well as males in equal numbers. In 50% of patients with toxic megacolon, the disease will be seen in its acute fulminating course. This is the first manifestation of ulcerative colitis. An additional 15% will develop this complication within the first year of their contracted illness. The time interval from the appearance of the diarrhea associated with the colitis to the fulminant course of toxic megacolon averages 16.3 days, but has been so violent as to have been noted within 3 hours of the onset of the attack, whether this be a primary attack or an exacerbation of a known disease state.

The symptoms associated with toxic megacolon are fairly characteristic. Diarrhea, anorexia, abdominal cramps, rectal bleeding are almost always the signs that accompany the process. Weight loss occurs in 90% of the patients and nausea and vomiting in 50%. Chills and fever have been reported in only approximately one-third, although fever itself exists in nearly 100% of patients with this disease. Tachycardia and abdominal tenderness are present. Abdominal distention may not be apparent in the face of a massively dilated colon, segmental or generalized. Signs of peritoneal irritation are present in approximately 50% and leukocytosis in 66% of patients. Evidence of liver damage is apparent in more than half of those afflicted. Hypocalcemia, hypoalbuminemia, hypokalemia, hyponatremia, and hypochloremia are also common accompanying features.

X-ray diagnosis is probably the key to the problem. Colonic dilatation is seen on a generalized basis in half of the cases while segmental involvement is detected in the other half. Serial X-rays are essential in following the course of the patient. The transverse colon is most severely affected initially. A barium enema is rarely required for diagnosis of this disorder and is usually contraindicated. Many studies have indicated severe complications following a barium enema, such as the precipitation of the disorder. Perforation of the colon also has followed barium enema. Abnormal proctoscopic findings are usually present. Edematous, friable, hyperemic mucosa typical of ulcerative colitis is found.

The initial therapy consists of antibiotics, corticosteroids, and nasogastric aspiration. While there has been debate concerning the use of steroids, most clinicians recommend their use.



Recent studies of patients with ulcerative colitis, chronic and acute, have indicated no greater surgical morbidity in patients treated with steroids, than in those who have not received steroids.

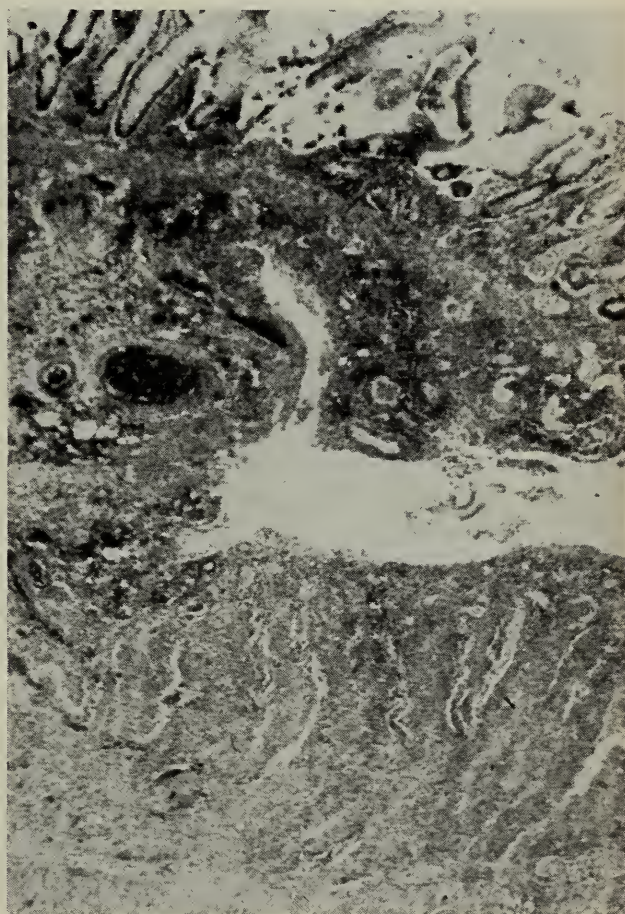
The majority of patients require operation. The number of patients who have been treated medically alone are small and there are few reported cases of people treated medically that have survived. The need for operation is based on the severe damage that has occurred in the colon, which is usually irrevocable. The complications of toxic megacolon are perforation and hemorrhage. Perforation occurs in 33% of the reported cases. The mortality associated with the operation in the face of perforation varies between 10 and 45%, with an average of about 25%, indicating the serious nature of this problem. The average time from onset of the illness to the intervention of surgery is 16.4 days as compared to the previous figure stating the appearance of the megacolon as 16.3 days.

The operation is designed to eliminate the target organ, the colon. Any operation short of removing the entire colon usually is unsuccessful and is associated with increased morbidity and mortality. Total proctocolectomy is the operation of choice, although in some patients, total abdominal colectomy may be performed and proctectomy accomplished later.

Operative complications which occur most frequently are wound infection, perineal infection, subphrenic abscess and wound dehiscence. Ischemic necrosis of the ileostomy, retraction of the ileostomy, and parastomal fistulae at the ileostomy may occur. Septicemia and septic shock account for the majority of deaths.

**Dr. Marshall Sparberg:** To reiterate just a little of what Dr. Haas has said, there are three causes of toxic megacolon: 1) The disease itself. She had a fulminant ulcerative colitis, seen in only about 5% of ulcerative colitis, but very severe and frequently terminating in colectomy within the first month of the disease, as hers did. 2) Hypokalemia. This may occur because of medications such as prednisone or diuretics or naturally, due to diarrhea. 3) Diagnostically. Toxic megacolon can be produced with the barium enema. Usually, I feel this is the preparation. If we give people laxatives, particularly castor oil or Duleolax, these may well produce toxic megacolon. This barium enema was performed in the unprepared state, and as such, I don't feel it participated in the production of her toxic megacolon. We have had patients who have had normal rectums proctoscopically who

had toxic megacolon due to ulcerative colitis, a rare situation where the barium enema was most useful diagnostically.<sup>1</sup> 4) Antidiarrheal agents. I think the most common cause of toxic megacolon is therapy. That is, we have a patient with diarrhea who is very sick and to whom we give parenteral anticholinergic drugs, such as propanthine, atropine, or the opiates. They stop having diarrhea and the abdomen starts to swell. The patient is momentarily delighted because diarrhea is no longer present but the physician is unhappy because he gets a film and it looks like the current patient's. In someone who has a fulminant ulcerative colitis with a high fever or high white count, one must not use these drugs. Unfortunately, we just have to let the patient have his diarrhea until the severe colitis remits.



**Fig. 5.** Photograph of section of mesenteric vein, showing fresh fibrin thrombus.

A word about the differential diagnosis. It used to be said that if you had a toxic megacolon, you were dealing with ulcerative colitis rather than granulomatous colitis. This still holds 98% of the time, but there have now been situations reported of toxic megacolon in granu-



lomatous colitis. The reason one does not see toxic megacolon in granulomatous colitis very often is because this disease is associated with a thickening of the bowel wall. The bowel is just too thick and stiff to dilate.

Roentgenographically, it is difficult to differentiate between granulomatous colitis and ulcerative colitis in this patient. In granulomatous colitis, heaped up mucosal tissue produces bumps protruding into the lumen. Here, those bumps really represent what is left of the mucosa with the submucosa being the area between protrusions. There is such a fulminant destruction of mucosa in these patients that it almost represents a separate kind of disease. Truthfully, the argument is somewhat semantic at this point, when one is dealing with a very ill patient who has a toxic megacolon.

The postoperative psychosis in this patient is very interesting and relatively frequent after surgery for toxic megacolon. Whether the etiology is related to steroids, related to the fact that she was sick, or other factors, is unknown.

Finally, I tend to be very aggressive with toxic megacolon. I agree completely with Dr. Haas, in that, once someone has toxic megacolon, this represents destruction of the mucosa with irreversible changes. Even though these patients may get over the acute episode, the colon is irreversibly damaged and the patient eventually will come to surgery. Some of the patients who appear in the literature as having recovered from toxic megacolon eventually had a second attack of toxic megacolon, fulminant colitis or other complications and ultimately came to colectomy. Thus, although the acute phase may be treated medically, ultimately colectomy will be required in these patients, so that I would suggest early surgery once the radiographic signs of mucosal destruction appear. I think the surgical judgment with this patient was superb, the perforation was diagnosed promptly, possibly because the white count failed to decrease, although there were no localizing signs.

**Dr. Stuart Poticha:** This morning's discussion led us to believe that toxic megacolon is a comparatively rare situation. In a large series of patients with inflammatory bowel disease from the University of Chicago, toxic megacolon was encountered in approximately 3%. However, from a surgeon's standpoint, it is seen more frequently as an indication for operation in people with ulcerative colitis where approximately 15% will

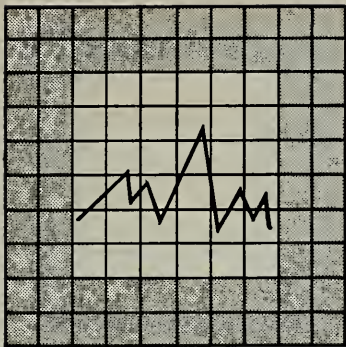
have toxic megacolon. The surgical treatment of ulcerative colitis for indications other than toxic megacolon has become uniform in the United States. Coloproctectomy is recommended in one stage. However, with toxic megacolon, the problem is more complex. The overall mortality rate of total colectomy in ulcerative colitis is approximately 5%. If cases of toxic megacolon are excluded, then the overall mortality of total coloproctectomy for ulcerative colitis drops to about 2%. If we consider the patients who have toxic megacolon, the operative mortality is around 25%. Most of this mortality is due to perforation, either spontaneous or during the course of the operation. The colon wall is extremely thin and mobilization of the colon is difficult without causing iatrogenic perforation. The mortality rate for the patient who has toxic megacolon with perforation is about 80%, as opposed to about 5% without perforation.

What is the best treatment for the patient who has a toxic megacolon with perforation? Many have written on this subject. The late Dr. Prohaska felt that the best operation for these patients would be abdominal colectomy with a mucous fistula and then ileostomy. He reported a mortality rate in patients with perforation of about 50%. Ileostomy alone is associated with a mortality rate of nearly 100%. Total one-stage coloproctectomy reported by Dr. H. William Scott<sup>2</sup> recently, has a mortality rate close to 50%. Less drastic procedures have been suggested. Lyons suggested ileostomy with cecostomy because of the extremely high mortality rate. Turnbull suggested ileostomy with what he calls a "blow hole" colostomy. The important question to answer in evaluating these procedures is whether such procedures prevent perforation, the reason for this high mortality. Does the colon perforate because it dilates and "blows" a hole through a weakened portion of the bowel or does the colon perforate because the disease extends completely through the wall of the bowel? The latter seems more likely. It is for this reason that most of the surgeons in the United States at the present time remove at least the abdominal portion of the colon. ◀

## References

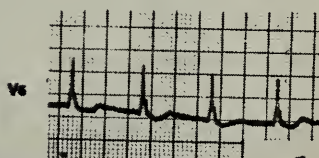
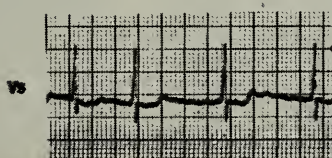
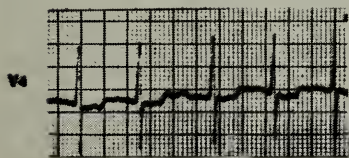
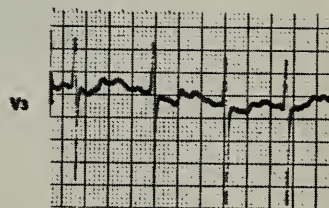
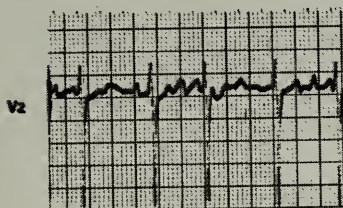
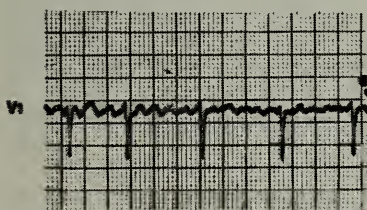
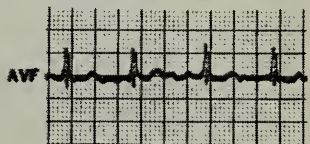
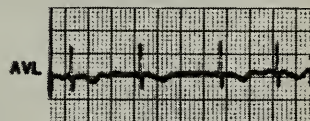
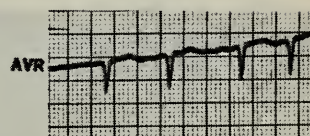
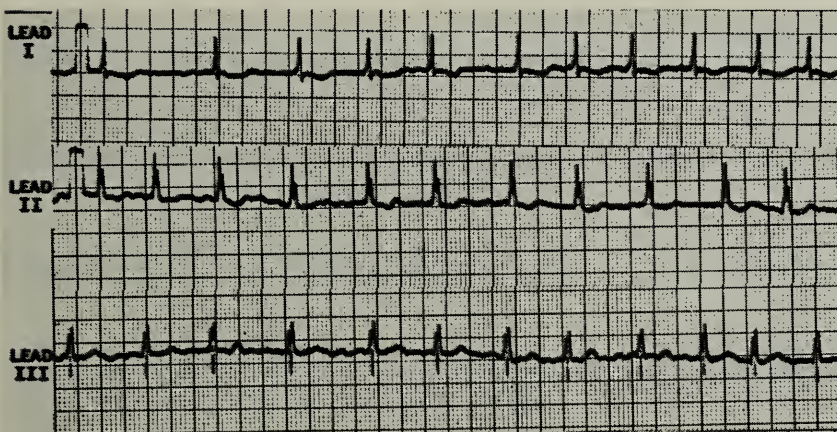
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# ekg of the month

By JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS, M.D. AND  
PATRICK SCANLON, M.D./SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE,  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



7

A 35-year-old white, female housewife was admitted complaining of severe dyspnea and orthopnea of 24 hours duration. She had simultaneously noted the onset of palpitation. Similar but milder symptoms had been present for 10 years. Examination disclosed neck vein distension at 45°; an irregularly irregular apical pulse, an easily palpable PMI in the 5th interspace and

the anterior axillary line;  $S_1$  of variable intensity at the PMI; and  $S_2$  accentuated (Pulmonic component) at 3rd Lt. and the sternal border. An  $S_3$  (Ventricular gallop sound), a 3/6 holosystolic murmur radiating to the axillae, and a short mid-diastolic rumble were present at the PMI. What's your diagnosis? (One or more of the choices presented may be correct.)



1. The electrocardiogram showed:
  - A. Sinus rhythm
  - B. Atrial fibrillation
  - C. Probable left atrial enlargement
  - D. Non-specific ST-T segment changes with digitalis effect
  - E. Atrial flutter

2. The probable clinical diagnosis is:
  - A. Mitral stenosis
  - B. Aortic stenosis
  - C. Mitral insufficiency
  - D. Aortic insufficiency
  - E. Myocarditis



## *November "Viewbox"—steak-eater's disease?*

December 9, 1970

Dear Doctor Van Dellen:

I would like to take issue with Doctor Love and his "View Box" diagnosis in the November issue of the *Illinois Medical Journal*, page 508. Doctor Love refers to the so-called "steak eater's disease" and goes on to describe it as an actual entity giving even an anatomic explanation for its occurrence. He confirms his diagnosis with the closing statement, "the esophagogram was normal after passage of the bolus."

The esophagus is a unique organ in many respects. It is not a rigid tube but rather elastic and can distend up to a large size without difficulty, to accommodate any bolus that can pass the pharynx. Primary and secondary peristaltic waves open the lower esophageal sphincter and propel food, etc., through it into the stomach. If Doctor Love's explanation of anatomical narrowing is correct in this man, then why did it take 50 years for it to manifest itself in him? To state that the esophagus is normal because nothing showed on the esophagogram afterwards is to completely ignore the fact that barium is a liquid and compressible bolus which passes easily, delineating only the most obvious strictures and is totally inadequate in demonstrating

esophagitis unless there are gross ulcerations.

I write this letter because (1) the barium esophagogram is not an adequate examination for delineating the cause of dysphagia. The esophagus must be examined by a bolus which stretches the esophagus and will not be compressed easily to pass an obstruction. (2) The use of meat tenderizer, advocated by Doctor Love, should be confined to the most remote areas where adequate medical care is not available. An impacted bolus is easily removed by esophagoscopy at which time the etiology of the obstruction is also ascertained. The pain accompanying an impacted bolus is severe, and the patient's distress quite real.

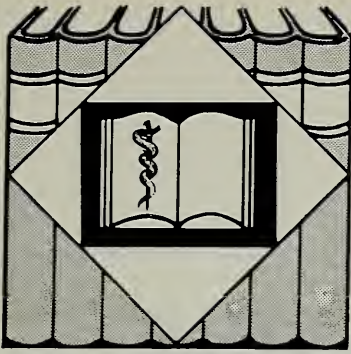
To close, the symptom of dysphagia should be fully evaluated by an esophagogram, the swallowing of a large radiopaque bolus, such as the barium marshmallow and/or esophagoscopy. I think when you do this you will find one of the numerous etiologies of dysphagia and it will not be "steak eater's disease."

Sincerely yours,

Charles J. Sigmund, Jr., M.D.

Department of Gastroenterology  
Carle Clinic





## the doctors library

**TRAINING FOR FAMILY PRACTICE** (Bibliography). By Mary Etta Zwell and Lucy Zabarenko, Ph.D. Staunton Clinic, 3500 Fifth Avenue, Pittsburgh, Pa. 15213. \$2.00.

This bibliography includes selected and annotated references in five areas: bibliographies in family practice, training in family medicine, instructional and evaluative techniques, and psychotherapeutic aspects of family practice.

Mary Etta Zwell  
Lucy Zabarenko, Ph. D.

**RH. ISOIMMUNIZATION AND ERYTHROBLASTOSIS.** Edited by Allen G. Charles, M.D. and Emanuel A. Friedman, M.D. Appleton-Century Crofts, New York. 235 pages, illustrations.

Drs. A. G. Charles and E. A. Friedman have done an outstanding job in editing and writing an authoritative, up-to-date book on Rh. isoimmunization and erythroblastosis fetalis. This book emphasizes the multi-disciplinary, team approach that is necessary for the successful practical management and the theoretical understanding of the complex problems of Rh. isoimmunization. Particularly good are the chapters on intra-uterine transfusions and clinical management of the affected infant. The only thing lacking in the book is a section on photo-therapy for jaundice due to erythroblastosis, which has been reported since the preparation of this book. The book should be in the library of every pediatrician doing exchange transfusions and obstetricians performing intra-uterine transfusions.

Harvey Kravitz, M.D.

**THE MANAGEMENT OF FRACTURES AND DISLOCATIONS.** By Anthony F. DePalma. Second Edition. W. B. Saunders Co. Philadelphia, 1970. Two volumes.

The author is to be complimented upon the production of a clear, concise, and comprehensive two-volume text on the management of fractures and dislocations.

The book is well organized and generously illustrated with appropriate and understandable line drawings. The first volume begins with a discussion of the principles of management, including an outline of types and causes of fractures, pathology, repair, and infection. The subsequent chapters deal with specific injuries including not only fractures and dislocations, but injuries to ligaments and capsules.

In general, the chapters are divided into injuries in particular anatomical areas, such as the pelvis, thoracic cage, humerus, elbow, etc. Each section begins with remarks which concisely describe the mechanism of injury, the basic clinical manifestations, the principle of treatment, and prognosis.

The text is presented adjacent to the line drawings and is highly practical. Potential complications are outlined, and where appropriate, operative management is included. Ample consideration is given to the management of fractures and dislocations in children, as well as in adult patients.

The book should be valuable to anyone interested in the treatment of fractures and dislocations and should be particularly instructive to resident surgeons during their training.

John M. Beal, M.D.

# hmo or fmc?

## Drastic changes ahead in medical care

BY JOSEPH LOTHARIUS, DIRECTOR, ISMS DIVISION OF ECONOMICS AND PEER REVIEW

"... preserving the free enterprise system of health care delivery depends on whether we make the right moves in the next five years." *Walter C. Bornemeier, M.D., President, American Medical Association.*

Statements such as this by our medical leaders plus ominous warnings by high ranking HEW officials of drastic changes ahead in health care delivery prompted ISMS to carefully consider the various new systems of health care delivery.

Two health care delivery systems that are being closely examined by ISMS Trustees are:

1. The San Joaquin Foundation for Medical Care, Stockton, California  
and
2. The Hennepin County (Minnesota) Health Care Foundation in  
Minneapolis.

It is possible that Illinois physicians will soon practice medicine under one of these proposals or a combination of both. The following questions and answers are intended to provide ISMS members with pertinent facts about each plan.



*1. What is a Foundation for Medical Care (FMC)?*

The San Joaquin FMC is a non-profit organization of physicians sponsored by a county medical society and concerned with the development and delivery of medical services and the reasonable cost of health care, whether privately or publicly financed. It is a separate and autonomous corporation apart from the county medical society, with its own board of directors.

Hennepin County calls its Health Care Foundation a non-profit instrument of the medical profession, dedicated to an equitable distribution of quality health services, and the elimination of wasteful, unnecessary, and expensive practices in the health care field. The business, property and affairs of the Foundation are managed by a board of directors.

*2. Who can join the FMC?*

In the San Joaquin plan, every physician member of the medical society may apply for membership in the FMC. Membership is renewed annually. After being accepted, physicians may participate in all FMC programs and activities. Members are assessed an annual dues of \$10.00.

Hennepin's FMC membership is open to any physician who belongs to a constituent county medical society participating in the corporate structure. Membership is voluntary and does not affect the physician's affiliation with the county medical society. There are no membership dues.

*3. What percentage of the physicians in the area participate in the Foundation?*

San Joaquin's FMC says the participation percentage varies between 60 to 93%.

Hennepin's FMC hopes to enroll approximately 75% of the physicians in the Twin Cities seven county area.

*4. How does the public benefit from an FMC?*

Both San Joaquin and Hennepin FMCs agree on the basic premise of providing patients with quality medical care. Both have established minimum standards to help assure consumers complete medical care at a price everyone can afford. Both attempt to protect the quality of health care and eliminate waste and abuse through extensive peer review. Hennepin's Foundation, however, is looking toward the expansion and development of health insurance to eventually cover the reasonable cost of all health services.

*5. Is the physician-patient relationship assured and the patient's right of free choice guaranteed?*

San Joaquin's FMC believes in the American tradition of free choice of a personal physician and hospital by the patient, the fee for service concept, and the local control of over and under utilization through peer review.

Hennepin County's FMC, like San Joaquin, guarantees patients the free choice of physicians and protects the patient-physician relationship, as well as the preservation of free enterprise in medical practice.

*6. When and why was the Foundation established?*

The San Joaquin FMC was established March 1, 1954. The FMC was organized at that time to combat the threat of the Kaiser-Permanente Foundation. The "threat" was the proposed establishment of closed-panel programs in hospital based group practices.

Hennepin County will begin operation February 1, 1971. It was established to provide the organization through which the medical profession may assure the availability of high quality health services to all residents of the area at reasonable cost.

*7. How can the FMC assure quality medical care?*

San Joaquin established a peer review committee during its first year of operation. Since then, Foundation physicians have accepted the peer review concept and expanded it to the utilization and quality review of all medical services that are physician-generated.

Review of fees and utilization by peers is designed to make sure the quality of health care is kept high, to insure that health money is well spent, to prevent overutilization and underutilization of services, to guard against malpractice and abuse, and to give the physician a continuing education by self-evaluation.

Hennepin County's FMC has a Peer Review Committee on Physicians' Fees and Services plus a Peer Review Committee on Institutional Services. These Committees established the usual and customary fee guidelines and the utilization guidelines mentioned above. All cases submitted to the Fees & Services Committee by either insurance carriers, prepayment plans, or participating physicians will be reviewed with the expectation that the Committee's opin-



ion will serve as a guide to both parties. If litigation should develop, the Committee will provide expert witnesses to support its judgement. The Institutional Services' Committee reviews those cases involving inappropriate admissions to hospitals or extended care facilities.

*8. How does the FMC obtain subscribers?*

In both Foundations, insurance carriers and prepayment plans are used to promote the purchase of FMC benefits by area residents.

*9. How are physicians' fee levels determined?*

The fee for service concept always had been upheld by the San Joaquin FMC. However, with the many ramifications of prepaying medicine and bringing adequate medical care to everyone within their ability to pay, the FMC feels the fee guidelines are necessary. Fee schedules are set by the Foundation on the basis of the California State Medical Association's Relative Value Study.

The Hennepin County Foundation will establish usual and customary fee guidelines based upon current charges for physicians in the seven county Twin Cities Metropolitan area. Periodically the general pattern of physicians' charges in this area will be surveyed so that the rate of fee escalation may be objectively measured. Guidelines for utilization of services have also been developed. Both these guidelines are made available to all insurance carriers participating in the Foundation program. The carriers agree to pay claims according to the guidelines.

*10. How are claims processed and reviewed?*

In San Joaquin County, all claims are reviewed medically by a physician member of the Foundation and contractually by claims personnel. In

most cases draft authority is secured from the various insurance and service companies. The Foundation is convinced that claims review and processing is an important administrative procedure in the interest of local control and responsibility.

Hennepin County makes its review criteria (established by appropriate Foundation committees) available to all Foundation participating insurance carriers, prepaid health service plans, welfare agencies, and fiscal intermediaries for Medicare for use in their appraisal of all claims involving health care. Each claim falling within the range of "norms" defined in the criteria will be routinely processed and paid by the responsible third party within the terms and conditions of its contractual obligations. Claims sent to the Foundation for screening and evaluation are those which fail to meet one or more of the standards applying to: 1) ambulatory physicians' services, by diagnosis; 2) appropriateness of hospital confinement by diagnosis, work-up, and treatment; 3) durations of hospital overstay and understay, by diagnosis; and 4) physicians' fees which exceed the usual and customary guidelines.

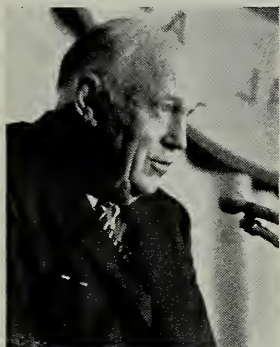
*11. What are the major differences between San Joaquin and Hennepin County FMCs?*

Claims processing and review seems to be the major difference. San Joaquin reviews and processes every claim and handles the reimbursements. This necessitates establishing a claims processing department much like that of insurance carriers.

Hennepin County's Health Care Foundation establishes norms for fees and utilization and obtains commitments from insurance carriers to follow these norms. The carriers process all claims and only submit those cases to the Foundation which fall outside of the norms.

# Leadership Conference abstracts

## "Health Care Delivery Changes in the 70s"



Roger O. Egeberg, M.D. is Assistant Secretary for Health & Scientific Affairs, U.S. Department of Health, Education, and Welfare.

### Today's health care delivery is sick

We have fundamentally two identifiable, if not wholly separable problems with respect to the delivery of health care. Without attempting to assign an order of priority, I believe we are confronted first with the critical maldistribution and misuse of health care resources. A situation made progressively more critical by a rising demand for health services that clearly exceeds our present capacity.

The second, but by no means lesser problem, is the inability of a great number of poor and near poor people to gain access to necessary health services for the simple reason that they cannot afford them.

No measure of success in improving the organization of health care delivery can be expected by itself to open up access for the poor. Conversely, no effort that simply enables the poor to buy health care is going to correct the flaws in the system. It could, in fact, make them worse by adding to the devastating rise in health care costs that affect not only the poor, but everyone.

It seems obvious, therefore, that we have to deal with not just one problem, but two. And that is precisely what this Administration intends to do.

Looking first at the problems of health care delivery in general, we find a somewhat paradoxical situation; the United States with one of the world's higher ratios of physicians to population, does not have enough doctors to go around.

Despite the fact that we operate more than a hundred of the best equipped and best staffed medical schools in the world, we still employ foreign-trained physicians in some 20% of the approved intern and residency training programs in American hospitals. A country that ought to be exporting medical expertise is, instead, importing it.

We find, moreover, that acute care facilities—general hospitals—are severely overcrowded because our health care delivery system offers little in the way of alternatives to this costly form of care. At the same time, we see the wasteful



duplication of expensive facilities and equipment because of a serious lack of effective planning geared to realistic needs.

It is utterly wrong to suggest, as some have, that the cause of our difficulties dates from the adoption of Medicare and Medicaid. While these two programs certainly had the effect of opening up some serious cracks in the structure of health care delivery systems by greatly increasing effective demand, they didn't cause the cracks. However, they may help to mend them. For acknowledging the difficulties and limitations of these programs, we believe that they can provide a base for substantial improvement in the way health care is delivered to the American people and in the capacity of the health care system to cope with the pressures of rising demand.

The Administration has taken or proposed a number of measures aimed at controlling the inflationary rise of health care costs and at improving the organization of health care delivery. To control costs we have:

- proposed to limit increases in the fees of doctors and other professionals under Medicare and Medicaid to an index related to the overall cost of living;
- proposed that reimbursement for hospital costs under Medicare be made on a prospective basis to encourage institutions, through financial incentives, to operate more efficiently and to require that they bear the risk of incurring higher-than-contemplated costs;
- asked for authority to terminate payments for services rendered by health care suppliers found guilty of program abuse, and to facilitate recovery of overpayments.

Apart from these largely fiscal and economic measures, there are many other steps that have to be taken. We have to expand the supply of health manpower; to train and use new kinds of professional and sub-professional health personnel; encourage the development of ambulatory care facilities and programs to shift the demand for care away from hospitals.

The Federal Government is not able to accomplish such changes by itself. The entire health enterprise, public and private, will have to work to bring about vast improvement in the system. We clearly have a major responsibility to use the vast amounts of public funds administered through public programs to encourage and support change and to create a climate in which new approaches to health care

delivery can succeed.

This is one of the chief motivations underlying the health maintenance organization proposal that is now before the Congress.

I would like to suggest in broad outline what I believe are the fundamental considerations that will have to underlie any and all efforts to deal with the health care problems facing this country.

First, I don't harbor the illusion that simply turning out more doctors will solve everything. It won't. But neither would the adoption of some new scheme of health care financing, such as compulsory national health insurance. Each of these parts of a comprehensive remedy may have its place.

Second, I would hope that we stop giving lip service to the idea of preventive health care and start doing something to make such care widely available and acceptable to the American people. Not only do we train doctors primarily to care for the sick, we train our young to seek health care as a last resort. Revising medical school curricula will do a lot toward placing additional emphasis on health protection, but we will also need help from educators, government, and the voluntary health movement, which has long been ahead of the pack when it comes to preventive medicine.

Third, I hope we will all bear in mind that it won't be easy to extend the reach of modern medical care into those areas that are badly in need of it.

If we can make more efficient and effective use of health resources and demonstrate the feasibility of bold and innovative new approaches to the delivery of comprehensive care, we may actually produce the dramatic changes that all—or at least most—of us recognize are essential.

The Federal Government, because it is a major source of funds for research, training, planning, construction, and the purchase of care, has a great responsibility to foster an environment in which change can occur. To some extent, perhaps, we can even impose change, but we cannot be the sole instrument of change. That initiative must come from the health industry itself, public and private, the academic community, medical societies and other professional groups, the health insurance industry, health agencies, hospitals and other health care institutions. The alternative would be national control, first of one aspect of the health enterprise—financing for example—then of others, and finally of the entire system. There are many thoughtful and serious people who believe that the only way out of our present dilemma lies in nationaliza-

tion of the health industry. I don't agree with them, and neither, I suspect, do most of you.

If there is a keynote for this conference, let it be a note of urgency, but also one of confi-

dence. The very fact that we gather to explore new ways to deal with grave problems means that we are at least intent on solving them; that is a vital step.



Emory G. Bullis is assistant director (liaison) in the Office of Program Planning & Evaluation of the Health Services and Mental Health Administration.

## HEW's Rx: HMO

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I would like to recount some of the thinking inherent in the health maintenance organization concept and review some of the questions we have been asking ourselves in the developmental aspects of the HMO program.

First, a brief narration of the ingredients of an HMO in the context of HR 17550, where it is included as an option to Medicare. The legislative proposals say that qualifying organizations may be profit or non-profit, private or public. Thus a medical society, a fee-for-service, a prepaid group practice, a hospital or university teaching center, a neighborhood health center, various profit-making organizations—all could determine that they would like to effectuate a prepayment contract with the Federal government on a predetermined prospective rate which would be negotiated annually.

In making the contract, they would agree to provide the equivalent services specified in Parts A and B of Medicare, to enroll beneficiaries of the Medicare program. At the same time, however, the HMO would have to show evidence that similar or comparable benefits and services are being offered up to an additional enrolled population group comprised of more than Medicare beneficiaries. The legislation stipulates that at least 50% of the enrolled group must be under age 65.

These contractors would be reimbursed prospectively by the Federal government on the basis of 95% of the going Medicare costs in the given area. The criterion for determining these area Medicare costs would not be nationwide, but more likely on a countywide basis. If the HMO is able to operate on the basis of less than 95% of total costs, the theory is that it may retain the so-called profit. On the other hand, should losses or total costs exceed 95%, this deficit must be absorbed by the HMO.

The organization would have to agree to provide the Parts A and B services minus the usual deductibles and co-insurance common to conventional Medicare. However, they would be permitted to charge the actuarial equivalent of the coinsurance under Part B and the deductible under both Parts A and B under Medicare. They would also be permitted to impose an extra premium charge for any additional services that might be incorporated in their program to make the offer more attractive. However, the extra premium and the extra services would have to be distinguished from the charges levied for the deductible and co-insurance equivalents.

The HMO would assume full responsibility for its enrollees in negotiating a contract under Medicare. This point prompts me to mention that similar responsibility would pertain to ar-



rangements under Medicaid. The legislative authority for Medicare beneficiaries which is now under discussion would not be necessary to permit the HMO to negotiate a contract with state Medicaid authorities. This can be accomplished administratively.

The law would not require that the organization have onboard every species of provider resource, the services of which are included under the Medicare program. Indeed it will be permitted and expected that subcontracting arrangements be rather common. A different relationship will make its appearance should the HMO legislation become a reality. Under the present Medicare program "certification" is the order of the day and best describes the relationship that a provider organization acquires in its dealings under Title 18. For a provider to participate in Medicare, a certificate of eligibility is the usual transaction that occurs. But in the instance of the HMO, the interested parties (i.e.,) the HMO and the Secretary of HEW, will of necessity sit down at the conference table and negotiate a contract. It should be apparent that one of the reasons for this approach is the need for both parties to have in writing the full terms of the services to be provided, the agreed upon capitation rate, etc.

This is more than a point of information and the contract aspects of HMOs are deserving of some emphasis because there has been considerable apprehension in many quarters over the prospect of "southern fried" health care, and implicit in this concern is the not unreasonable proposition that goes something like this—"for years many of us have been saying there must be a better way to run a ball game, but we never did say that we were in favor of crass commercialism of the sort that might squeeze profits out of human misery." Obviously we share the concern expressed in this proposition, and the thinking is that the Secretary of HEW should have absolute control to negotiate as well as to refuse to negotiate or renegotiate contracts with any HMO.

Conversely, it is reasonable to convey the sentiment that language might well be incorporated in the legislation which would specify the extent to which any organization might accrue profit margins under such a program. One school of thought suggests the proposition that there should be equitable distribution of profits amongst enrollees. For example, beyond a certain profit margin the HMO would be required to increase benefits or reduce costs for its membership.

When we turn to the marketing aspects of prepayment programs, and in this sense the marketing of the HMO concept, we might stop for a moment and say—"more easily said than done." It would seem that the growth of prepaid group practice, closed panel type arrangements, will be consistent in some measure with the abilities of third-party payers to employ mass marketing expertise and motivate consumers toward participation in these type programs. There would seem to have to be a comparable marketing undertaking to cause proliferation of the foundation packaged prepayment program. Yet it would not seem that the development of medical foundations per se would have to be directly linked to the marketing aspects as would prepaid group practice plans. I say this because many foundations which are now in their early stages of development are using Medicaid as a test run and contracts with Medicaid authorities in various states do represent a rather large block of so-called "business." I have strayed somewhat from my narration of what an HMO is, but I wanted to give you a look at some possible directions HMO development might take. This is to say that we might look toward the quantitative expansion of the HMOs in somewhat sobering terms. It does appear that prepaid group practice plans of the closed panel type will and certainly should expand, but their development would in some measure seem to have to be commensurate with the trend in third-party sources which are actively engaged in a major marketing effort, the fruits of which are yet to materialize.

As I said earlier, the objective in promulgation of the concept of the HMO is to encourage development of complete systems of health services which feature prepayment as opposed to postpayment for health services. It has been said that perhaps we are trying to strive toward the goal of shaping an American model of the Chinese concept of health services which, as we all know, stresses payment for well services, no payment for sick services—except that in China the HMO which cannot perform when sickness strikes, probably gets something in addition to non-renewal of the contract!

Seriously, it does appear that the thrust of this proposal of the Administration is by way of asserting that for too long we have been in the habit of piecemealing all of our financing of health care in the United States. And one of the casualties of this system, in addition to cost escalation, is the great neglect of preventive care.



Donald C. Harrington, M.D. is medical director of the San Joaquin Foundation for Medical Care.

## FMO: "A better cure"

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My assignment is to describe a system of health care delivery that can; 1) utilize various methods of financing; 2) maximize peer review; and 3) increase comprehensiveness of coverage. I'm speaking for the Foundations for Medical Care.

The foundation concept started in 1954 and has so far spread to 22 counties in California and actively into four other states. There are 6,000 doctors in California under contract to the various foundations for medical care and over 8,000 MDs in the rest of the country. There are over one million people on contract to foundations for medical care coverage.

The foundation is a wholly owned corporation, owned by the county medical society. It is the county medical society's fiscal and administrative arm to handle the medical and economic problems of that area.

It is not just for insurance; it is to handle the total problems of medical care in the area. There are two types of members—the administrative members are the board of directors of the county medical society in whatever county the foundation is located. This board elects a Board of Trustees. It in turn manages the affairs of the foundation which is a corporate structure.

The participating members are the members of the medical society who agree to participate under the terms of the contract. The participation percentages in our county vary from about 60% to about 93% of the physicians. So the organization is important in that it gives control to the medical society.

The foundation works as a partnership. The first partner is labor and management—the trust funds. Their job is negotiation, e.g., develop the funds to purchase whatever kinds of insurance they can afford.

The insurance industry, such as the Blues, make up the second partner. They develop the thinkers, the actual statistics, rate the programs and carry the risk. They also sell the program through the broker and agency systems.

The foundations describe the scope of benefits, the fee schedule under which we are willing to work, and do peer review.

These are the three major thrusts. The fourth partner is government, which has been impacting us in private practice more as time goes on. First with the federal employees' contract and now with Medicare and Medicaid.

Now to discuss the Foundation responsibility. First the minimum standards. People throughout the country are becoming more and more desirous of comprehensive medical care, which is a challenge for our present system. Unlike other insurance companies, like the Blues, we offer coverage from birth, excluding the nursery charges. We also include all consultative services in and out of the hospital.

The second thing we feel important is coverage of all diagnostic services in or out of the hospital. This is something else not offered in most other contracts.

In regard to fee schedule, we have three different areas of payment: for people who make below \$5,000; people earning \$5,000 to \$7,000; and for people who are above \$7,000.

The third and probably most important function of our foundation is peer review.

When you increase the comprehensiveness of medical care to the out-patient area, it is opened up to people who over-utilize laboratory work, or people who utilize office visits too frequently. Then the problem of peer review becomes increasingly difficult.

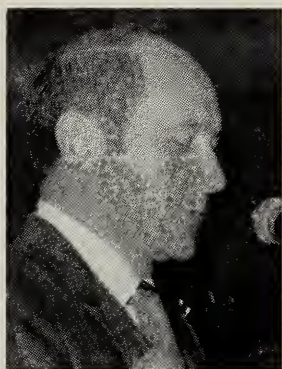
I think that peer review in the outpatient area is very important. In our foundations on



the West Coast we have been reviewing both Medicare and Medicaid for the last three years, and that review for fee saves about 1½%. Review for over-utilization at first saved us 15% and is now leveling off at 10%. This is a meaningful review, which hits a small percentage of our physicians, but these physicians need to be hit. So again, our minimum standards that make our program comprehensive are fee schedules relating to what we are charging—not what we would like to charge. Careful review to make sure that the program is not overutilized is our part of the bargain with the people. We have produced the best kind of medical care and we believe that it is not in spite of fee for service. It is not in spite of the freedom of choice of the physician and patient but it may be just because of it. For this reason we feel that the

fee for service properly administered and properly disciplined is the way to do it. The foundation for medical care programs puts a clinic next door to every patient because every doctor's office is a clinic.

We have booklets for all of our groups printed by the insurance industry. Each has a foundation page, saying "The Foundation for Medical Care is a medical organization in San Joaquin County sponsored by your county medical society. The purpose of the foundation is to provide the best medical care for the people of San Joaquin counties. The foundation for medical care believes in the principle of voluntary prepaid medical and hospital insurance. The foundation further believes in the time-tested American tradition of free choice of personal physician and hospital by you the patient."



Richard E. Anonsen is president of the Hennepin County Health Care Foundation, "Hennepin County (Minnesota) Program."

## Hennepin County's program

The Health Organization Plan in San Joaquin follows the Hennepin County Health Care Foundation, not the HIC Plan. Approximately 18 months ago, our Board of Directors sat down to decide its future in the social and economic area of medicine. We, too, have gone through the "watch and wait" attitude on the Medicare/Medicaid programs. We, too, had experienced defiance, opposition, and repression. We knew we would have to change the pattern to be involved in the architecture of our future.

We are not responding to a fear of closed panel programs, but to news media showering the American public with devastating degradation of physicians. We are responding to graphs in national magazines showing health care costs going from 4.1 to 60 billion dollars from 1950 to

1969. We are responding to a 5.8% increase in medical costs as compared to 3.1% for other consumer items. We are responding to six proposals before Congress, all National Health Insurance schemes. We are responding to social welfare costs in our community, which increased from \$694,000 in 1946 to \$35,000,000 in 1969.

We are aware that approximately 10% of this money went to physicians, most of it to the heads of nursing homes for custodial care of elderly patients. We felt we were directly involved. After all, we ordered their laboratory work and their drugs. We worked with their families who put them there. We decided to become activists in our own community. We were aware of the excellent planning program Dr. Donald Harrington had been doing in San Joaquin, and

we spent a total of four days seeing his program in action.

Because San Diego was similar in population to the Minneapolis area, we also flew down to San Diego and watched the action there. We learned a great deal from Dr. Harrington and the San Diego group. We began to adapt these concepts to our area. It has approximately one million people and wide diversification of industry. We have the largest insurance center west of Chicago, and 50% of the population is covered by Blue Cross and Blue Shield. We have approximately 1,400 practicing physicians. We have 17 voluntary hospitals—no proprietary hospitals. We looked at total claims review in our area, approximately 170,000 per month. Where would we get 800 people—or a computer to run a claims review? Computer lease costs were estimated at \$44,000 per month, or \$3,000,000 to purchase a computer. We didn't have the space or personnel available in our community or the funds to pay for the personnel or the computer.

We looked at San Joaquin's experience over 16 years. After 16 years, they were reporting about 50% of the claims were reviewed by the 10 insurance companies involved. We looked at San Diego after 4 years as of April 4, 1969. They were covering about 64,000 of the 1,000,000 residents, with 8 to 10 insurance companies involved. We looked at Portland, where, after two years, the foundation idea faltered. We looked at Nevada. They, too, went to San Joaquin and went home, vitally interested in the program, but then forgot about it. We looked at Evansville and Dayton, who designed a foundation program on inadequate precepts. The Blues countered with an 80/20 package. This neutralized foundation plans.

We could go on and on. These are some of the things we had to consider, when we wanted to tailor make a foundation for our community. We were interested in quality control, utilization control and costly structures.

At San Joaquin, the physician in the hospital submits a standardized claim form, which goes to the commercial insurance industry and to

the Blues. There eligibility is determined, and the claim is reviewed. We have what we call norms. This is where medicine belongs in the insurance industry—to develop the criteria for quality, utilization, and possibly structure. We have done this by diagnosis for both ambulatory care and hospital care.

We have done nothing to date on the fee structure. We are waiting for the information gathered by in-putting computers. We will use that information, plus the California Relative Value study used in 1969, plus the Minnesota index which we have been using since 1963, as our reference material.

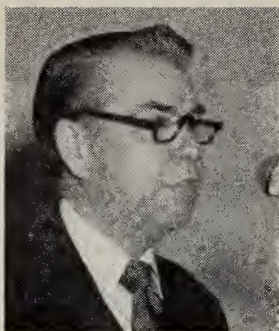
A claim will go to the insurance industry. If it falls outside of the established norms, norms of quality utilization and cost structure, it will be sent to the medical foundation for review. The norms will be given to the insurance companies that sign our participating agreements and to the physicians in the community. The Medical Foundation's review committee has committees; a service fee committee for ambulatory services and a utilization committee for the hospital. Our utilization committee will be made up of two representatives from each of the 17 voluntary hospitals, the County Hospital and the University Hospital. Decisions will be binding on the physician, the hospital and the insurance industry.

We don't have any problems with our physicians, except in two areas: those physicians who are way outside of what is the normal usual and customary are opposing us; and the physician who is in his 60's, has maybe 4 or 5 more years of practice, doesn't want us to make waves.

For our foundation structure, we have incorporated labor, management, hospital administration, a representative from the Blues, and a representative from commercial insurance, into our Board of Directors.

We are interested in up-grading neo-natal coverage, obstetrical coverage, and ambulatory coverage in our community as well. We think this is particularly important in cutting down the cost of health care.





Thomas H. Ainsworth, Jr., M.D. is associate director of the American Hospital Association and chairman of the AHA's Committee on Physicians.

## **American Hospital Association views**

Physicians must take a leadership role in shaping the health care delivery patterns of our country, but this must be done in cooperation with all other providers of health care and it must be sensitive to the needs of the consumer, our patients. I do not mean that hospitals should take over the system, but I do mean, by virtue of their organized medical staff, their resources of allied health professionals, their facilities and experience in health care administration, that they are the logical institution in the community; the one which has the potential to be the catalyst to simplify a sensible health care system.

Unfortunately the average physician mistrusts the hospital; this is a strange paradox. It's intimately associated with his daily practice. It is really his professional home and the physician is vitally concerned about the welfare of the institution; he calls it his institution, and yet this mistrust persists.

Why? I believe it is because physicians have been denied any role in the management of the institution. The physician feels that his upward mobility within the institution is limited to the attainment of the head of the clinical department or the presidency of the organized medical staff. His upward mobility in management or governing of the institution is blocked at this point.

Actually when organized medicine asked for a role in government, it was because they felt that the administrator was so firmly entrenched in his position that he would not share the management of the institution with the medical staff and their only hope was to by-pass the administrator and again a role on the hospital Board. Actually I believe what the physician really wanted and really needs is a voice in the management of the institution.

Many of our problems today, especially the cost of medical care in our hospitals, is due to

the fact that the physician has no role in management. He has no voice in such things as the creation of the hospital budget, no knowledge of the cost of the services; and, therefore, no sense of responsibility in these areas. The physician will only assume greater responsibility for the care he orders if he is given a greater responsibility in the total management of the institution.

The Bennett Amendment or the Social Security Amendment of 1970 would give control of delivery of health care to only one of the providers of health care. It happens to be organized medicine. I would feel just as strongly if hospitals were given this exclusive right to set up a control mechanism. I mention the Bennett Amendment to serve as an illustration of what I am talking about—that unless all providers of health care join forces to develop a better health care system, the government will eventually control us all.

The American Hospital Association believes the concept of giving physicians a role in the management of our institution is not only a desirable course, it is a necessary one in order to preserve the voluntary hospital system, and preserve, for the physician, a free enterprise system to medical practice; a system based on competition with minimum government control and with maximum freedom.

We have not taken the leadership role in eliminating the inequities of the present system. Neither have we been responsive to the needs or desires of our patients. We must eliminate a two class system of care which we now have and begin to focus on the maintenance of health and the quality of life rather than on illness alone.

So let's compare these two systems (HMO & FMC) on the basis of their potential.

Is the old charity system being preserved by

the Foundation? I see no leaders, no incentives. In fact, I am forced to agree with the image of the Foundation—designed to preserve the status quo. Unless organized medicine changes this image of the Foundation, then it could be a mechanism to hasten socialized medicine.

What's the potential for the HMO? The theory is certainly one of free enterprise. It has competition and free choice of the patient built in. There is not real interference with patient-physician relationship, but this, of course, will depend largely on the relationship of the individual physician within the group. There is a built-in incentive to keep people well and out of institutions. It eliminates the two class system. Since it unites all providers of care, education could eliminate the barrier of ignorance. Its size alone gives a greater potential to the answer of the geographic barriers by establishing communication and transportation services. Of the two systems, I believe it has the greatest potential, because of the corporate structure.

I believe it is time for us to take a look at other industries and see if we can learn something from them; for health care is an industry. It happens to be, at the present time, the third largest in the United States, and it is expected by 1975 to be the largest industry. The corporate structure has served industry well. Perhaps the corporate power of physicians and institutions combined in a single organization with one

purpose—better provision of health care—could have great potential.

The corporate structure has more advantages. Physicians want a voice in the management decision, and yet they want to preserve for themselves all clinical judgments. The corporate structure allows this. They are guaranteed upward mobility and therefore can control their own destiny. The physicians want the freedom to join or leave a system. The HMO system would assure this. The physicians want no change in their relative position in the social and economic structure of the country. The HMO system certainly answers this objective. There are advantages to the patients as well and to other purchasers of care, whether they be the government or third party. There would be higher quality of care. Peer Review mechanisms and Utilization Review are also excellent management tools, when conducted on the management level, with physicians assuming equal responsibility for the total operation of the institution the physician is apt to be more objective. The services would be more patient oriented because they would more strongly express the knowledge of the physician in regard to patient needs. I believe if I had a choice right now, I would choose the HMO system, but I think we should study both of these before we try to adopt any one single system, but again the poor government is the motivator. What can we do together?



Louis A. Orsini is director of the Health Insurance Council representing the private insurance company's interest in the health care field.

## **Health Insurance Council's formula**

This variation of the Foundation as it has been developed on the West Coast by the physicians is a very strong physician-sponsored program. We have been privileged to relate, to consult, to confer, but the decisions have been made by the doctors. Now I want to visit

with you about re-emphasizing or stressing the climate which you are in today. It is clear, with the build-up of consumer interest and concern of cost, that with the proposed changes that are under consideration for Medicare and Medicaid, we may possibly end up with universal



National Health Insurance. The sense of urgency comes with the questions—"Who will control and how?" We think these questions will be determined now. Let me emphasize that in evaluating the general objective there is no disagreement with the fundamental premise that the design pattern should leave the ultimate responsibility with your profession, provided the need for consumer involvement is recognized. The pattern must be practical, it must be objective, and it must be responsive to major cost and quality concern.

HIC has felt that its role has been fundamentally one of what I call the objective catalysts, e.g., to reflect in your internal evaluations those areas where history has demonstrated that your program is subject to critical question or scrutiny. We believe that no one pattern as yet has emerged as a prototype. We do think, however, that the Hennepin County program has unique potential at the present time because of the following general characteristics:

The scope of the program, as outlined by Dr. Anonsen, is responsive to the major cost and quality concerns. It brings them under objective evaluation and review. It will permit a measurement of the number of cases that fall outside the prevailing fee guide established by the profession. It will permit evaluation of what happens to those cases by the profession in such a way, that when a reduction is recommended the consumer's interest is protected, namely we change fee, or change the price to the consumer. It is responsive to an evaluation of ambulatory physician services and the number of diagnoses involved there brings it under an evaluation on the norms established by the profession.

It brings under evaluation virtually all of the reasons why an individual may be admitted to the hospital and the appropriateness of the period of time that the individual is in the institution, both from the standpoint of understay and overstay.

We think that the program has unique features which will contribute to its objectivity in terms of physician acceptance and consumer acceptance. First, there is a very important principle of accountability building the idea that the Board composition involves a recognition of the fact that the medical profession must relate to the other members of the Health Care Team. It must invite their involvement and still stick to the majority vote. Really, the involvement is the important point and you must bring about that kind of dialogue between hospital administration; between the planning field and all third

parties which permits us to constructively figure out what are the best answers to the problems we find.

Now I want to also emphasize in terms of objectivity, the reference made this morning by some gentleman, to dishonest insurance companies. We think the answer to dishonest insurance companies is not to do business with them, but to design your program so that the option to request review remains with three parties—the physician, the patient and the carrier. We think there has to be periodic evaluation too, and this is all built in to the approach of the overall experience which has to be demonstrated conclusively by monitoring most of the major things that are going on.

You hear a lot of conversation whether the HIC, the prepaid group practice approach or the cheaper service medicine, (you make your choice) produces better quality care at a lower cost. Well, this approach gives us a reasonable index to prove or disprove the allegation of opponents' ideas. Since you will have a unit cost established by the profession which is a good bench mark, you will have criteria for evaluating qualities and you will have criteria for evaluating on the basis of medical judgment the other factors that go into the delivery of medical care, so that the comparison then can be expressed in terms of a comparable level of cost, productivity and price. We think there is another series of practicable aspects to this approach. First there is one of economy. You heard about the Foundation cost in various areas of the country. The doctors have borne the cost of putting together their screening guides. Currently the doctors are going to bear the cost for professional time expended in the evaluation of cases that fall outside of the guidelines, but the carriers will assume the cost of applying the guidelines to the normal plans of the administration. The carriers are assuming the costs in this program in the development of charts data which will re-erect the current charge pattern in the community used as a basis for a screening guide in evaluating unit costs or fees. In the compilation of the program, we like the concept of using the technical competence of the carriers to do what they normally do, administer claims.

The application of your screening guides, to involve them in the evaluation of the cases that exceed those guides, also offers a practical incentive which avoids the logistics of the training, and the additional costs of setting up a Foundation to do a good job on your own. We think too that the idea the physicians support accepting the opin-

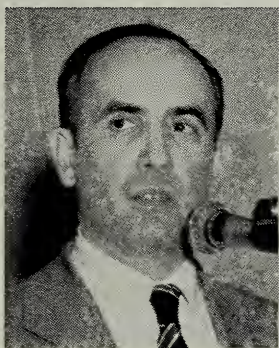
ions of the Foundation, as well as changing the rate at which the carrier pays for care, is vitally needed to protect the consumer's interest. There has been no single criticism of past peer review activity as important as that where the committees have rendered an opinion which have permitted us to adjust our payments or have frequently left the patient with the obligation of absolving the difference.

We think that there is another practical advantage in the fact that the program can be made operative very quickly. By quickly, I mean that with the groundwork that has been done in areas as Hennepin, made available to any other medical society, it will shorten the consideration period.

We think too that the involvement of administration becomes important because there will be situations where the committees' review will demonstrate that the major reasons for the overstay was not because the post-operative period

was incorrect but because the pre-operative period was incorrect, presenting a problem for administration. What we are saying is lay out the program so that you produce an objective evaluation and involve the principles from the word "go," so that as you proceed to correct the problem, you have coordination and support in whatever you are doing.

I would like to leave you with one observation that I picked up as I traveled around the country, talking to doctors like yourselves. I want to re-emphasize that it is not too late. Intelligent, statesman-like leadership is needed from the medical profession. While I emphasize that the Health Insurance Council will cooperate and has cooperated with all interested medical societies in devising better solutions, we think this one has a great deal of promise, and we are anxious to work constructively and are eagerly awaiting the initiation of the program and a demonstration of FMC's.



James M. Ensign is vice president of the National Blue Cross Association.

## **Nat'l Blue Cross views alternatives**

Some of the alternatives Blue Cross views are HMO's, foundations, cooperative arrangements between insurers and foundations, hospital-based group practice and a number of others.

If you are interested in the HMO type of activity, don't let that interest be reined in to wait for the passage of H.R. 17550, or any other piece of legislation. Those of you who have been through Medicare or Medicaid will recall that such legislation will require lengthy regulation writing, bargaining and contract negotiations.

It's far better to have a plan so that the government will be interested in participating in *your program*—not you in *theirs*.

The CBS network spent two hours of prime time last fall telling us two things: our health care delivery system is in a mess; and the solution to that mess is universal adoption of the Kaiser-Permanente prepaid group practice pro-

gram. Now, if it took them two hours to make those two points, you can imagine what a challenge it is for any of us to discuss the relative merits and demerits of various alternative forms which range between the mess that they talk about and Kaiser-Permanente.

It just so happens that we in Blue Cross are very much interested in the spectrum of efforts that go between those two points. And rather than try to oversimplify it by saying HMO has this advantage and this disadvantage . . . or foundations have these advantages and these disadvantages . . . we're much more interested in seeing what happens locally. It's not for us at the national level to preach to those of you who are going to make some changes in the system—even if they're modest ones. If the changes are in the public interest, we applaud them . . . we want to cooperate.



Let me just talk about that spectrum for a moment. It includes physicians, like you, who are reluctant to sign a contract to be bound to another organization—even if it's a peer organization—for fee adjudication or utilization review adjudication. We find as we move down the spectrum, physicians willing to cooperate with foundation activity and be guided in the amounts of money they receive . . . or the way in which their claims are treated by their peers. We move down the scale a little farther and we find a hospital-based medical staff discussing the financing mechanism with the administrator. Then we move on down the scale and we talk about the HMO concept.

As we view these arrangements, we tend to view them as basic criteria, not as individual programs. It's not HMO against the world or peer review as the only way to go.

Reasonable access to care is something that everybody wants to have. Interestingly enough, we did a study a couple of years ago for a book we published called *Sources*. The study was designed to point out the differences in the ways in which poor people perceive their health care problems. The significant thing to me, however, was not the fact that poor people were more worried . . . but that the majority of the people in the middle income group were worried too. So we're in favor of anything that helps the American people have a more rational understanding—whether it's education or a new system, or both—about how to get in and out of health care delivery and how to maintain health. This includes expanded public accountability programs and providing benefits as alternatives to the in-patient stay.

A big problem that hasn't been discussed to any great extent today is adding the on-the-hook benefits to the basic package of in-hospital benefits. These are not simple trade-offs. We don't simply reduce hospital days and take the money and hand it to people and say, "go get the care standing up." It doesn't work that way. One, the people buying protection don't want to give up hospital days, and secondly, when you add outpatient or ambulatory benefits, the price goes up, because as soon as people move through the system on an ambulatory basis, there's going to be some initial discoveries of problems that will

put people into the hospital. This is a short-term phenomenon.

Another thing to think about very seriously is the fact that the public isn't necessarily interested in adding in-patient benefits. The big hue and cry now is for things like out-of-hospital drugs, dental benefits and a number of other glamor benefits that they think are more important . . . or they perceive as being more important than frequent visits to the physician.

I think we're all for improved distribution of health manpower facilities, but we're not quite sure how this will solve the problem. Productivity through incentives . . . provider risk sharing . . . greater predictability, quality and costs controls . . . improved and simplified administration and other health-related matters certainly need to be considered. Don't just pin everything on the health delivery system.

When people begin to talk about the subject of national health insurance, they drag out the vital statistics and the health comparisons between ourselves and other countries. Let's face it, we could revolutionize the health care delivery system tomorrow and not bend those statistics very much. We're talking about other things in our environment besides how to patch up people who are already ill.

We're talking about adequate diet, non-smoking, accident prevention to name a few. When I mention them, I'm told I'm copping out because I'm not willing to take the blame for the fact that there's a differential in vital health statistics between countries. Regardless of that fact, I think we have to focus more on other health-related problems.

We have taken a Board position at National Blue Cross that no single delivery system will suffice for a nation as diverse as ours . . . in terms of efficiency or as an answer to the many values being weighed by providers and consumers of care. In pursuit of greater efficiency and effectiveness of delivery and financing, it's important that the consumer have reasonable options available.

New health care systems—impeded by artificial restraints on experimentation or implementation—will rigidify and, in the end, result in problems in both care and access. For that reason, when we look at these various alternatives, we hope that a good number of them will be colored Blue.

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### Editor's note:

Foundations for Medical Care took a giant step toward becoming a reality in Illinois when ISMS' Committee on Health Care Financing agreed to recommend the establishment of a non-profit corporation (FMC) sponsored by ISMS. The committee made its decision after months of careful deliberation and many discussions with national experts in this field. The recommendation will be considered by the Board of Trustees in January. According to the Committee's recommendation, the Corporation would cooperate with prepayment plans, insurance carriers, government agencies and others in providing health care, with the further objective of meeting the requirements of a professional service review organization (PSRO) and other appropriate health care delivery systems established by law. The Corporation would be organized in compliance with all legal requirements and provide for full autonomous participation by local medical societies or groups of medical societies.

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## *Hospital admission program controls costs*

Rising hospital and medical care costs can be realistically controlled and in some instances even lowered, a health care official has reported.

Dr. James Bramham, president of the Medical Care Foundation, Sacramento, Calif., reported that his group was working on costs through a new peer review system of hospital utilization control.

Dr. Bramham, speaking at the Health Insurance Council's conference on health care held in November, in Chicago, identified the new system as "CHAP," Certified Hospital Admission Program.

He cited a one year pilot program for 800 printers and their families, consisting of over 2,000 lives covered by group health insurance.

He said the results of the program which ended September 30 were:

- Hospital utilization down 17% without complaint from members insured.
- Members going to a Foundation doctor have 93% of their charges paid for hospital, physician, surgeon, laboratory, and X-ray services.
- Only 41% of the benefits paid went for hospital charges, underscoring the successful shift to more outpatient treatment.

When the group was given its choice of programs in October (between the Foundation and the Kaiser program), 96 per cent elected to re-

main with the Foundation.

Dr. Bramham said the Foundation was based on a system that discouraged overutilization of hospitals while "seeking less costly alternative methods and places of treatment whenever possible."

He listed the following methods which he said health care people must adapt to continue quality care while lowering costs:

1. Treat all patients outside of the hospital when possible.
2. Keep necessary hospitalization to a minimum.
3. Use lower level of institutional care when possible in the continuum of intensive care, regular hospital care, E.C.F., custodial, home care, and office care.
4. Avoid unnecessary diagnostic and surgical procedures and office visits.
5. Prescribe less expensive satisfactory medications when possible and prescribe nothing when nothing is indicated.
6. Seek the least costly satisfactory home health care aides, assistive devices, and other medical services and supplies, and prescribe them no more than is necessary.
7. Continue to make the necessary effort to see that the least expensive satisfactory methods for diagnosis and treatment are made available to our patients.



The word "hypochondriasis" is more a term of opprobrium than an official diagnosis. However, we all believe we know what we mean when we refer to a patient as a hypochondriac.

It is, of course, assumed that a sufficient physical work-up has been done to assure us that his complaints either have no physical pathological basis, or that any pathology which has been discovered cannot account for all of the patient's symptoms, or for the degree to which he claims to be suffering. Next we must eliminate the question of malingering, therefore a conscious and willful pretense of disability. The patient behaves as a malingerer in an effort to avoid a real situation to which he cannot adjust—a real and imminent problem which he can see no way of solving. The behavior here is *consciously* determined.

This is, in itself, a mentally pathological way of behavior in the face of a realistic problem, and in fact, if malingering is discovered, it is necessary to try to discover why the patient has chosen this technique if the patient will let you.

It is not easy to make the diagnosis of malingering; usually it can be verified only by the patient giving himself away, e.g. being observed in full activity at a bowling lane when he keeps insisting he cannot work because of pains in his back or hip joints. Here it nevertheless remains the physician's duty to get the patient to reveal his problem and why he has not tried to meet it more realistically.

I will now refer briefly to a number of conditions more readily accepted as psychologic in origin, but where the patient concentrates exclusively on somatic symptoms.

Here it soon becomes clear what the underlying psychiatric diagnosis really is.

A patient with an hysterical paralysis, or other form of dysfunction or complaint, is not consciously or willfully manufacturing his disability to avoid an emotionally disturbing issue. Although he is often well aware of the existence of a problem, he is

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not aware of any link between that problem and his clinical state. The physician, having determined that there is no physical basis for the disability, should note in his patient an absence of manifest anxiety, with on the contrary, the presence of a degree of unspoken satisfaction. This is what has been called "Belle Indifference"—meaning that the patient seems to be relatively unconcerned about his disability. He accepts it and wishes that everybody else would—at home, at work, and in the physician's office. If it is accepted, he will soon give up asking for it to be "cured." He will not spontaneously be a recurring visitor to a medical facility. He may, however, be an unwilling one because he is urged "to get something done about it" by a wife, parent, or insurance company. It must be watched then that we do not apply the term hypochondriac to a man who is being frequently advised, instructed, or pestered to go to a physician.

A somatic complaint without physical basis is very often a pointer to an underlying state of depression—a mood, the presence of which the patient himself may not

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John Cowen, M.B., Ch.B., D.P.M., is clinical professor of psychiatry at the Chicago Medical School and staff psychiatrist at Hines Veterans Hospital. He received his M.B. and Ch.B. from Edinburgh University and his D.P.M. from the Royal College of Medicine & Surgery, in London. Internship and residency were served at mental hospitals in Great Britain and the British Royal Army Medical Corps.

recognize.

A very useful thing to keep in mind here is that a complaint of rapid loss of weight, or an observation which indicates this, e.g. obvious looseness of the clothing, can be an indication of a depressive state as often as it is an indication of malignant disease or subacute infection which used to be the case with tuberculosis, or hepatitis today. Other phenomena due to depression will become apparent on asking—anorexia, in-

satisfied if you treat him as a case of true angina, because he then has certification of a physical disability. On the other hand, if you tell him he is having anxiety attacks and needs treatment for these, and he refuses to accept this diagnosis, and tries to get you to change your mind, or leaves you for another doctor, then you might want to say this is indeed a hypochondriac. You should reconsider this, because all the patient really wants is for you to classify him as a

# hypochondriacal patient physician's office

somnia, constipation, amenorrhea, loss of interest in one's environment, and possibly, and very reluctantly, even some degree of feeling hopeless about being able to be helped.

Sometimes recurrent attacks of anxiety are accompanied by such over-whelming somatic components that these are what the patient talks about rather than his mental unease. A common complaint—especially in these days of extra public consciousness of heart attacks and transplants—is of attacks of an anginal type of pain. These are of course distressful of the patient and real enough in spite of normal EKGs and Master's tests. One must pay persistent attention to the descriptions given by the patient about the temperature of the emotional environment, and of the feelings of the people in it, when he does get such an attack. Then will appear the realization that the patient is having anxiety attacks and that these are what must be dealt with rather than the patient's fears of having heart disease.

In this type of neurotic state, as happens comparably in hysteria, the patient becomes

cardiac invalid so he can settle into a plateau of contented invalidism.

Now recall the patients coming to you regularly with a sequence of new symptoms experienced in new ways. These people welcome any new technique you suggest for further evaluation. Needles and scopes do not deter them; you can look into any orifice with any size tube; they will even permit you almost eagerly to manufacture artificial orifices to let you peek at places not accessible via normal orifices. If you do find some minor pathology, they will again undergo all kinds of inconveniences and discomforts to let you treat or even remove that piece of tissue. If they can persuade you to do an encore to take out a piece believed to have been left behind, or a "something" which resulted from the original operation, this seems to please them too, although—again—for only a very brief period.

If you have to tell them that the latest cystoscopy, or whatever, shows no indication for further intervention, they reappear with symptoms which you feel to be a temptation to get you busy with another



kind of scope, or more exsanguinations for even further tests.

You begin to wonder if this sort of patient isn't in fact setting up a situation of challenge. He is in effect saying, "I've got something physically wrong somewhere. I defy you to find it. You may think you are a clever doctor, but I am more clever than you because I can prevent you from ever finding it." The patient is not coming to you to be healed, or for a final diagnosis. He comes to you to pit your skills as a learned professional against his own fantasies that he can outsmart you. The patient, in fact, is taunting the doctor.

Not only does the patient defy one doctor but the defiance becomes offered to each new doctor approached.

Here is a profile of the patient:

1. The school, work, and social records are disorganized.
2. Reality is evaded by flights into illness, manifested by groups of symptoms pointing vaguely, and at various times, to different organs and systems.
3. The patient has submitted himself to a myriad of expensive, painful, and time-consuming investigations which almost never reveal an organic pathologic basis for the complaints.
4. He has never accepted this but continues to insist on endless repetitions of these investigations.
5. Where there is any hint of pathology and this becomes known to the patient, he seeks surgical "cure;" and then further surgical aid to counter the "complications" of the first operation.
6. He so woefully misinterprets any medical explanations given to him that they become grotesque beyond the bounds of mere ignorance.
7. He begins to believe that, so far, no one has really "understood his illness" and keeps seeking the one doctor who will "cure him." Yet having found that doctor, he never follows through on the prescribed treatment, other than sometimes accepting instrumentation or open surgery. Prescribed treatments are tried for a day or two, if at all. Yet he fails to accept his personal responsibility for cooperation.
8. When he has exhausted his financial resources he becomes a chronic "clinic" attender, often being a secret habitue of several clinics simultaneously.
9. He becomes more and more critical of doctors who do not cure him, and of a society which finds it increasingly difficult to accept him. He may go on to quacks and to extol the miracle cures which they may momentarily achieve with him. This aggravates his already embittered feelings about the medical profession.

This is a description of the 100%, hard-core, apparently uncrackable hypochondriac, and I suggest that such an individual is in fact psychotic.<sup>1</sup> He is suffering from the delusion that he is being plagued by a disease which is so mysterious in site and in origin that it will require the efforts of a super-physician to unravel the mystery, and he keeps looking for this super-physician. At the same time, the patient also has what amounts to a delusion of grandeur—his illness is such that NO doctor can get to the source of it, that is, this patient and his sickness are together able to outsmart every doctor alive—hence the element of defiance with which such a patient displays his symptoms in your office. He really does not want to be cured, he merely wants to score one over on you and thereby show you that your own doctorly omnipotent fantasies are being bested by his. He is prepared to undergo any indignity or suffering to beat you in this struggle—hence his submission to a variety of scopes and whatever surgery is recommended.

At the same time he is defying you, he is also becoming increasingly angry that none of his doctors—or his family—"understand" him. In fact, by this time he has usually alienated himself from his family, because they have all become thoroughly tired of his chronic demanding invalidism.

This increases the patient's conviction that nobody even wants to understand him; his explanation for the intolerance of others then becomes paranoid.

He sees nothing in his own behavior or attitude which indicates other than that he himself is suffering—through no fault of his own—yet everyone is cold, hostile and rejecting him. This is the mental technique known as projection. It is characteristic of

the paranoid way of misinterpreting emotions in the interpersonal situation.

There are also other "supernatural" things going on simultaneously. For we can discuss this at the level of magic, in which most of us still have an abiding faith. For what other reason do we swallow vitamins, hang baubles from the rear-view car mirror, and drive cars far more powerful and gaudy than are necessary for transportation? Fur coats are not warm when worn with the skin outside, but we wear them that way to show our enemies that by wearing that skin we have acquired the cunning or ferocity of the animal to which it originally belonged. Sheepskin is usually worn with the wool inside, and rabbit skin is dyed to disguise it as some more malicious creature.

Similarly, many patients seek magical influences to aid their quest for health. Particularly is this so in the case of the deluded grandiose patient whom we are discussing, for what he is really after is to pit his magic against yours. You give him a prescription with polysyllabic and Latin hieroglyphics scribbled on it. To him this has the equivalence of an amulet. Often enough he does not take it to the drugstore—instead he carries it around with him in his wallet for weeks on end—as it were challenging the inscription itself to remove his complaints. If he does fill the prescription, he takes only one or two of the tablets prescribed and leaves it at that—perhaps because he fears lest your magic turn out to be indeed more potent than his. If your power does prevail, he will really lose his symptoms and his whole *raison d'être*—his reason for being—(which is his existentialist way of looking at himself) is to play to the hilt, the role of the incurable sufferer whose search for the unconquerable healer is doomed to failure. That has become his cross, and he takes a masochistic pleasure in bearing it.

You must surely all recognise that individual. This is the patient who improves after a few sessions under the diathermy machine then relapses as the mystery of the machine with all its lights and knobs begins, through increasing familiarity, to lose its magic.

Having recognized what is really going on emotionally in the hypochondriac, what can be done?

First you have to weigh your own

level of tolerance. You have to be able to show the unhappy man or woman a mixture of benign firmness with patience to listen—not for more than 10 or 15 minutes—but regularly and with an established fully ritualized appointment system.

Gently yet firmly you must tell the patient that you are well aware his complaints are real; that whatever physical pathology is present has been, or is being, brought under control (but this you do with absolutely minimal doctoring); and that you expect him to stick with you and not to go shopping for other doctors, chiropractors, osteopaths or nature healers; that he keep away from his friendly neighborhood drugstore in search of over-the-counter remedies for nerves, sleeplessness, tired blood, gas on the stomach, or insufferable headaches which don't seem to interfere with his dining out in noisy, stuffy, overheated and overcrowded restaurants.

You tell him that you do not intend to take any more X-rays or try any more manipulations or surgical procedures, and that if any medication is indeed necessary, you will prescribe the minimum and will expect the patient to adhere to the exact regime.

You tell the patient you have already heard enough about his symptoms and bodily complaints; and that, instead, you want to hear only about what is going on in his home life, social life and work situation—that is, if he has any (most of those people have none of these). They find a substitute for them in their complaints, and in your waiting rooms which are, for them what clubs and Saturday night rendezvous are to you.

However impoverished his interpersonal activities and relationships may be, these are what you want him to talk about.

Then you must tolerate a period of complaining about people instead of bodily dysfunctions. The persecutors will change from being mysterious disorders and incompetent physicians to his relatives, his past or present employers, and all kinds of "theys" who exist essentially in his fantasies.

You have to give him several sessions to get into this as his main theme, because he will try hard every so often to reintroduce the medical pitch which had become sec-

*(Continued on page 84)*





## practice management

This is the first of a series of articles concerning the physician's office management, written by Professional Business Management, Inc., Chicago, a medical management firm, which also serves as editorial consultants to *Medical Economics* and *Physician's Management* magazines.

### *Plan now for '71 tax returns*

BY ROBERT P. REVENAUGH/PROFESSIONAL BUSINESS MANAGEMENT

Now that 1970 is completed, you are undoubtedly preparing information for the completion of your Federal and State Income Tax Returns. While we can offer very few generalized tax gimmicks that would benefit all of you for 1970, nonetheless, now is the time to plan for 1971. After preparing thousands of doctors' income tax returns and defending many doctors in tax audits, it is our belief that a good office girl and a good bookkeeping system will yield greater sustainable tax deductions than the genius of the tax preparer. Most doctors' tax audits are won or lost on the basis of month-to-month substantiation. Doctors, as any IRS agent knows, are notoriously poor bookkeepers, but a good aide following a good system can save a doctor hundreds of dollars in taxes.

Let us start first with tax fraud. Tax fraud carries with it the penalties of imprisonment, criminal fines and civil penalties. However, just as significant are the legal and accounting fees necessary to defend oneself—win or lose! The trick is to avoid the investigation to begin with. By properly recording and depositing all of your practice receipts, by having a yearly total of services rendered, and by maintaining a proper control of accounts receivable most any fraud challenge by IRS is thwarted. Most challenges occur as a result of a routine audit where your bookkeeping system is lax or at the insistence

of a dissatisfied patient. Interestingly, we know of several Illinois doctors who did not properly report taxable income because it was embezzled by the office aide. Embezzlement by the office aide is not a defense to failure to report income unless embezzlement can be proved. This is sometimes quite difficult. It is possible that you may not only have money stolen from you, but likewise be taxed on money you never received, unless your bookkeeping system is sufficiently tight to prove embezzlement. We know many of you who read this article think this would never happen to you. We once asked an IRS special fraud agent what he would do with a country doctor, the medical savior of the community, who by design or neglect had not reported all of his income. The agent remarked—"make an example of him, all the newspapers would carry the story."

With good income and services rendered records, during an ordinary audit the agents will seldom look at the day sheets and account cards. They focus on deductions taken by the doctor. To sustain any deduction, the doctor must first prove that he paid for the item. Accordingly, all disbursements should be paid for by check. If you pay for a deductible practice expense in cash, submit a detailed bill and be reimbursed in the office by check.

To sustain the deduction of a practice connected expense you must not only prove the expense was in fact made, but also that the expense was "reasonable and necessary" to the conduct of your practice. Most often the agent will want to see the paid bill for which each check was made. A good system for the orderly retention of these bills will help assure the deduction.

The most commonly disallowed deductions are those involving auto expenses, entertainment, meetings and conventions. Auto expenses are commonly disallowed because the doctor attempts to deduct commuting expenses, but seldom do the doctor's expenses include his cash-out-of-pocket when he cannot pay by charge card. If these expenses, such as car washes, tolls, and parking fees were routinely reimbursed by the office to the doctor, he could sustain a higher deduction. Entertainment expenses fail to be sub-

stantiated primarily because the names of the people entertained are not listed. Without the names of these people the doctor can seldom recall the nature of the entertainment. Once the names of the people entertained are apparent, if as part of new patient procedure the source of reference is recorded, the causal link is established between the people entertained and the business desired. With regard to meetings and conventions, a doctor should maintain a diary of out-of-pocket expenses. Few doctors have the inclination to keep these detailed records. We generally rely on the business office aide to implement the systems. If she can obtain the information from the doctor while it is still fresh in his memory, it will be available for an inspection which may occur years later. This data may be worth hundreds of dollars in tax savings!



## medical legal review

### *Your nurse should be a notary public*

With the complexities of modern-day business and the need to be able to authenticate and legally verify some records, it is almost essential that all offices have a notary public.

Specifically, in the case of the physician, it is good procedure to have all medical consent forms notarized. This not only adds dignity to the form but legally it prevents the patient from later denying the signing or contending that it was obtained under duress or without proper understanding.

Having a member of the office personnel become a notary public is not difficult. It is only necessary to fill out the application forms which may be obtained from the office of the Secretary of State of the State of Illinois. At the time of returning the forms, a bond in the amount

of \$1000 must be provided either by a surety company or by the signature of two citizens owning property. In many instances, the same agent or company which writes insurance coverage will provide all of this service for a minimal fee. After the notary commission is received it must be registered with the local county clerk.

In addition to the above, each notary must have a metal seal which usually may be obtained from a local stationery store or a shop which makes rubber or metal stamps. This is a one-time purchase and is usable for as long as the commission is continued. The seal must be affixed to all documents notarized.

The notary commission must be renewed every four years. The total cost, exclusive of the seal, is less than \$20.00.





## public affairs

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### *House Ways & Means Committee chairman comments*

#### *On the role of HMOs*

Rep. Wilbur D. Mills (D., Ark.) expressed concern about claims that prepaid group health care, or health maintenance organizations, could solve most of the problems of medicare and medicaid.

Speaking to a group of business executives, the chairman of the House Ways and Means Committee, which handles medicare and medicaid legislation, said he believed health maintenance organizations were "a reasonable and perhaps competitive alternative" for providing government-financed health care.

Mills said he expects health care spending figures for fiscal 1970, which ended July 1, to show that \$7 out of every \$100 spent in the United States for all goods and services went for health expenditures. "Just three years ago,"

Mills said, "it was estimated that we would not reach the 7% level until 1975."

He noted, however, that the fiscal 1970 figures would show "for the first time" that federal spending did not increase as fast as private spending for health services.

"The reason for this development is that the medicare program did not grow as fast as it had been growing," Mills said.

Mills said the new health care figures point out two major characteristics of the health industry—"rapidly escalating costs and rapidly increasing public involvement."

"Public funds now pay for one-half of all the hospital care provided in the country," Mills said. "Medicare and medicaid together account for almost all of the half."

### *Catastrophic illness coverage plan to go before 92nd Congress*

National health insurance is shaping up as one of the major domestic issues before the 92nd Congress with catastrophic illness coverage gaining support from both Democrats and Republicans.

Sen. Russell B. Long (D., La.) announced he would offer a catastrophic illness coverage plan to the finance committee of which he is chairman.

Long's plan called for the government to pay 80% of all medical costs beyond the first 60 days of hospitalization or the first \$2,000 of physicians' bills for all Americans who pay social security taxes and are under 65. He estimated the cost at \$2.5 billion a year to be financed by a one-half of one percent increase in social se-

curity taxes, to be shared equally by employers and employees.

The American Medical Association also cleared the way to add catastrophic coverage to its Mediredit plan for voluntary national health insurance. The House of Delegates at the AMA 1970 clinical convention in Boston approved a report of the Board of Trustees listing catastrophic coverage among the modifications and improvements being considered before reintroduction of the Mediredit legislation.

All national health legislation introduced during 1969-70 died with the final adjournment of the 91st Congress, and some modifications were expected to be incorporated in most of the leading proposals before their reintroduction in the 92nd Congress.

## ***Congress approves family practice & birth control bills***

Congress in the final days of the 91st Congress approved two important medical bills dealing with family practice and birth control.

The main feature of the family practice legislation authorized a three-year, \$225 million program to help medical schools establish and operate departments to train family physicians.

A family planning bill authorizes birth control services, except abortion, for all American women who cannot afford them. The birth con-

trol services will include contraceptive drugs and devices, as well as consultations, examinations, and instruction.

The legislation also provides for federal aid for birth control research and establishes an Office of Population Affairs in the Department of Health, Education and Welfare.

To finance the program for the first three years, House-Senate conferees agreed on a compromise authorization of \$387 million.

## ***Senate panel calls for monetary crusade against cancer***

A special panel of Senate consultants urged a multi-billion dollar crusade against cancer to erase its "staggering" impact of death and suffering on all mankind.

In a brief but detailed report to the Senate Labor and Public Welfare Committee on its four-month study of the disease, the 26-member panel estimated that 50 million Americans now living will develop the disease and that 34 million of them will die unless immediate steps are taken to curb it.

The consultants recommended a sweeping pro-

gram keyed to consolidation of all existing cancer research projects into a national cancer authority directly responsible to the president.

It recommended doubling cancer research spending to \$400 million in the 1972 fiscal year, and increasing it by \$100 million to \$150 million in subsequent years to a \$1 billion level in 1976.

Last year only 89 cents was spent for each man, woman and child in the United States on cancer research, compared with \$140 per capita on national defense, \$125 for the Vietnam war and \$19 each on space programs and foreign aid.

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# new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.  
**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Products**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

\* \* \* \* \*

The following new drugs have been marketed:

## New Single Chemicals

**BETAPAR** Hormones-Corticoids R

**Manufacturer:** Parke-Davis

**Nonproprietary name:** Meprednisone

**Indications:** Inflammatory, allergic and rheumatic diseases responsive to corticosteroids.

**Contraindications:** Active, healed or incompletely healed tuberculosis except to control toxicity or overwhelming tuberculosis infections. Ocular herpes simplex, primary glaucoma, acute psychosis, diverticulitis, recent intestinal anastomosis, active or latent peptic ulcer, Cushing's syndrome, renal insufficiency, hypertension, thromboembolic tendencies, osteoporosis, diabetes mellitus, myasthenia gravis, acute or chronic infections, exanthematous diseases, fungal infections, and pregnancy in the first trimester.

**Dosage:** Individualized

**Supplied:** Tablets, 4 mg.

**LYSODREN** Cancer chemotherapy R

**Manufacturer:** Calbiochem

**Nonproprietary name:** Mitotane (USAN)

**Indications:** Inoperable adrenal cortical carcinoma of both functional and non-functional type.

**Contraindications:** Known hypersensitivity to the drug. Temporarily discontinue **LYSODREN** following shock or severe trauma and administer exogenous steroids.

**Dosage:** 9-10 gm./day in divided doses, q.i.d. or t.i.d.

**Supplied:** Tablets, 500 mg.

## New Indication

**PERIACTIN HCl** Appetite stimulate R

**Manufacturer:** Merck Sharp & Dohme

**Nonproprietary name:** Cyproheptadine HCl

**Indications:** Appetite stimulant in children

**Precautions:** Should not be prescribed for children for longer than 6 months.

**Dosage:** 2-6 yrs.: ½ tablet t.i.d. with meals.

Over 6 yrs.: 1 tablet t.i.d. with meals.

**Supplied:** Tablets, 4 mg.

## Duplicate Single Products

**ANGIBID** Vasodilators-Coronary R

**Manufacturer:** Meyer

**Nonproprietary name:** Nitroglycerin

**Indications:** Angina pectoris associated with or resulting from coronary insufficiency, coronary artery disease, coronary occlusion or myocardial infarction.

**Contraindications:** Early myocardial infarction, severe anemia, glaucoma, increased intracranial pressure, idiosyncrasy.

**Dosage:** One capsule before breakfast and at bedtime (at 12 hr. intervals).

**Supplied:** Timed action capsules, 2.5 mg.

## CALCIUM GLUCEPATE

**INJECTION** Hospital solutions R

**Manufacturer:** Abbott

**Nonproprietary name:** Calcium glucoheptonate

**Indications:** Hypocalcemia

**Contraindications:** None mentioned.

**Dosage:** i.m.: 2-5 cc

i.v.: 5-20 cc

**Supplied:** Ampuls, 5 cc representing 90 mg. calcium

**CORTIFOAM** Hormones-Corticoids R

**Manufacturer:** Reed & Carnrick

**Nonproprietary name:** Hydrocortisone Acetate

**Indications:** Topical treatment of ulcerative colitis and ulcerative proctitis and as an adjunct to other measures.

**Contraindications:** Obstruction, abscess, perforation, peritonitis, fresh intestinal anastomoses, extensive fistulas and sinus tracts. Tuberculosis (active, latent or questionably healed), ocular herpes simplex and acute psychosis are considered absolute contraindications. Relative contraindications include active peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, diverticulitis, thrombophlebitis, psychic disturbances, pregnancy, diabetes, hyperthyroidism, acute coronary disease, hypertension, limited cardiac reserve and local or systemic infections including, fungal or exanthematous diseases.

**Dosage:** Usual dose: One applicator once or twice daily for 2 or 3 weeks, and every second day thereafter administered rectally.

**Supplied:** Aerosol foam, 10%

**FERGON** Hematinics o-t-c

**Manufacturer:** Breon

**Nonproprietary name:** Ferrous gluconate

**Indications:** Iron deficiency anemias

**Contraindications:** None mentioned.

**Dosage:** Usual daily dose, 1 capsule. May be increased for more severe anemia.

**Supplied:** Capsules, 435 mg. (50 mg. elemental iron)

## Combination Products

**GAVICON** Antacid o-t-c

**Manufacturer:** Marion

**Composition:** Alginic acid

Sodium bicarbonate

Aluminum hydroxide

Magnesium trisilicate

200 mg.

70 mg.

80 mg.

20 mg.

**Indications:** Temporary relief of heartburn caused by the reflux of acid from the stomach.

**Contraindications:** None mentioned.

**Dosage:** Chew 2-4 tablets after meals and at bedtime, followed by one-half glass water.

**Supplied:** Tablets

**RONDEC-DM** Cold preparations—General R  
**Manufacturer:** Ross

**Composition:** Each cc contains:

Carbinoxamine maleate	1 mg.
Pseudoephedrine HCl	30 mg.
Dextromethorphan HBr	4 mg.
Glyceryl guaiacolate	20 mg.
Chloroform	0.70 mg.
Alcohol	6%-

**Indications:** Control of unproductive cough and mucosal decongestion

**Contraindications:** None known

**Dosage:** Infants 1-18 months,  $\frac{1}{4}$ -1 cc q.i.d.

**Supplied:** Bottle, 20 cc with calibrated dropper

#### New Dosage Forms

**RONDEC-DM** Cold preparation—General R  
**Manufacturer:** Ross

**Composition:** Each 5 cc contains:

Carbinoxamine maleate	2.5 mg.
Pseudoephedrine HCl	60 mg.
Dextromethorphan HBr	15 mg.
Glyceryl guaiacolate	100 mg.
Chloroform	3.5 mg.
Alcohol	6%-

**Indications:** Control of unproductive cough and mucosal decongestion.

**Contraindications:** None known

**Dosage:** 18 mos. - 5 yrs.: 2.5 cc q.i.d.

6 yrs. and over: 5 cc q.i.d.

**Supplied:** Syrup, 16 fl. oz.

**TOTACILLIN** Penicillin & Derivatives R  
**Manufacturer:** Beecham

**Nonproprietary name:** Ampicillin trihydrate

**Indications:** Infections due to susceptible strains of Gram negative and Gram positive bacteria.

**Contraindications:** History of allergic reaction to any of the penicillins.

**Dosage:** Adults: 250-500 mg. every 6 or 8 hrs.

Children: 50-100 mg./kg./day in divided doses every 6-8 hrs.

**Supplied:** Oral suspension, each 5 cc (reconstituted suspension) contains 125 or 250 mg. ampicillin.



## editorials

### ***Hold the line against inflationary spending***

President Nixon's determination to hold the line on government spending to avoid inflationary deficits deserves the nation's strongest support.

We commend him for his courage in vetoing four appropriation bills to let Congress know his intentions. The bills he vetoed would have appropriated \$2.4 billion more than his budget requests.

We agree with the President when he says:

*"I am determined to hold the line against a dangerous budget deficit" and "We must draw the line and stick to it if we are to stabilize the economy."*

(Note: We are heading for a \$10 billion or more budget deficit this year—the 10th in 11 years—following a decade in which the Federal Government spent \$57 billion more than it took in.)

And we agree with the President when he says:



*"When government spending gets out of hand, consumer prices go out of sight" and "We cannot have something for nothing. When we spend more than our tax system can produce the average American either has to pay for it in higher prices or higher taxes."*

(Note: During the past decade the cost of living rose 31½% and the value of our dollar shrank 24 cents.)

A look at our \$382 billion federal debt will give you a good idea how deep a hole we are digging ourselves into. The \$19.3 billion interest cost on the debt last year averaged out to more than \$52 million a day.

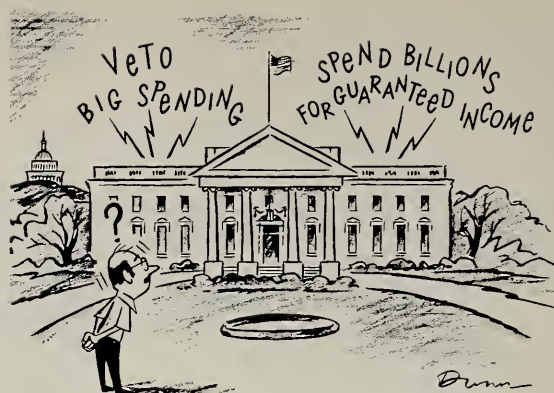
Every additional dollar of debt would at compound interest of 7% cost us another dollar in 10 years.

With estimates of budget deficits running as high as \$15 billion for this fiscal year and even larger for 1972, the specter is raised of another possible \$25 billion deficit such as occurred in 1968 and sparked the inflation we are trying so hard to control now.

These circumstances make it particularly unwise to inaugurate at this time a revolutionary and costly Family Assistance Plan with its guaranteed income that would expand welfare rolls by 128% and increase welfare costs another \$5-6 billion a year—and not solve the *real* problem of Aid to Families with Dependent Children (AFDC).

This cost would be just a start, because history proves that new social programs have a habit of expanding beyond all expectations.

While the Administration is proposing a minimum family income of \$2,465 for a family of four (\$1,600 in cash and \$865 in food stamps), others in and out of Con-



Can We Have It Both Ways?

gress are proposing higher guarantees.

So there is no telling what the costs would be and how much taxpayers would have to pay to help support the one out of eight persons who would qualify for welfare. The past record is startling.

In the five years of Medicaid, the number of persons getting federal assistance has more than doubled and the cost quadrupled to \$2.8 billion.

Unless taxes for hospital insurance under Medicare are increased, the program will run up a deficit of \$9.4 billion over the next five years.

Social Security benefits and taxes have risen to the point where a family of four earning up to \$5,000 pays more in Social Security taxes than it does in income taxes, And will go higher.

The battle against inflation is far from won. If we are to win it, we must apply the brakes, rather than accelerate deficit spending. And we must match it with tight monetary policies.

The alternative is higher federal taxes, and a Harris Survey shows what the public prefers: Almost 250% more favor spending cuts than higher taxes.

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# Diphtheria in Chicago 1960-1970

(Continued from page 39)

more striking. Only 11 patients were from families in which both parents were born in Chicago or other areas in the Northern United States. (Table 5) In contrast, 29 of the 43 Chicago born patients had a parent born in the Southern United States, Puerto Rico or Mexico. The importance of these data becomes immediately apparent when one considers the recent geographic

distribution of reported diphtheria cases in the United States. (Fig. 4) In 1968, for example, 94% of the reported cases occurred in the South and the attack rate in the South was about 40 times higher than for other parts of the United States.

It was not possible, in retrospect, to quantify the frequency of recent travel to the South that may have occurred among family members

Table 4

Diphtheria cases and Carriers by Age and Clinical Category, Municipal Contagious Disease Hospital and Other Reported Cases from Chicago, 1960-1970.

Age	Cases			Carriers		
	M.C.D.H. cases	Other Chicago cases	Total cases	"Outbreak carrier"	"Endemic carrier"	Total carriers
1-4	12	8	20	3	0	3
5-9	15	10	25	9	0	9
10-14	9	5	14	6	3	9
15-19	1	1	2	3	3	6
20-39	0	1	11	2	3	5
Over 40	1	1	2	0	5	5
Totals	38	26	64	23	14	37

Table 5

Place of birth of patients and parents of Chicago born patients who were treated for diphtheria infections at the Municipal Contagious Disease Hospital, 1960-1970.

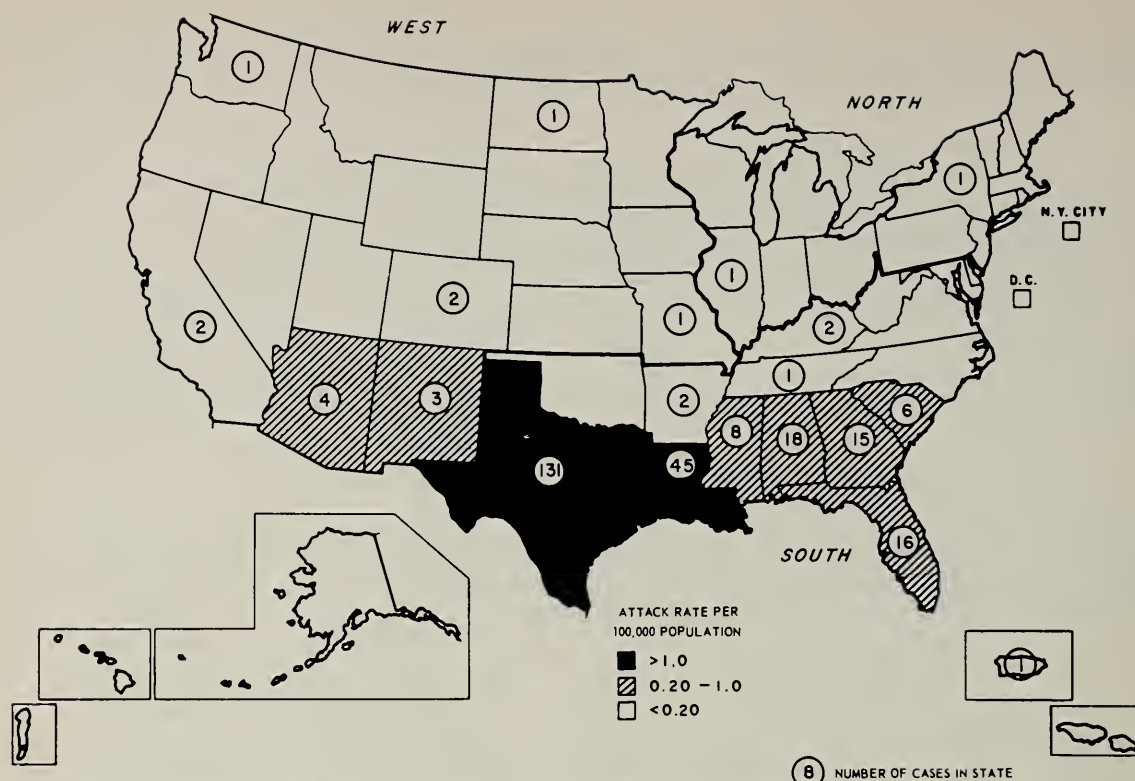
a. Patients (78)

place of birth	Number of patients	Percent of patients
1. Southern United States (Ala. 8, Miss. 6, Tenn. 3, N.C. 2, Tex. 1, Fla. 1, Wash., D.C. 1)	23	29.5%
2. Puerto Rico	5	6.4%
3. Northern United States (Ohio 2, Mich. 1, New York 1)	4	5.1%
4. Philippines	1	1.3%
5. Korea	1	1.3%
6. Germany	1	1.3%
7. Chicago	43	55.1%

b. Place of birth, parents of Chicago-born patients

Place of birth	Number of patients	Percent of patients
1. Southern United States (Ala. 7, Miss. 6, Tenn. 3, Ark. 2, Fla. 1, Okla. 1)	20	46.5%
2. Puerto Rico	8	18.6%
3. Mexico	1	2.3%
4. Spain	1	2.3%
5. Northern United States (Mich. 2)	2	4.6%
6. Chicago	9	20.9%
7. Unknown	2	4.6%





**Fig. 4.** Reported cases of diphtheria and attack rates per 100,000 population by state and region, 1968.

and friends of the patients; however, contact with an area of high diphtheria incidence is felt to be important in the epidemiology of the disease in Chicago.

There were 18 patients (23.1%) among those seen at M.C.D.H. who had Spanish surnames. Seven (29.2%) of those not hospitalized at M.C.D.H. who were reported to the Board of Health had Spanish surnames. In contrast only an estimated 200,000 (6%) of Chicago's 3,329,000 population is of Spanish stock.<sup>7</sup>

Fifty-five of the M.C.D.H. cases were white, 21 were Negroes and two were Oriental. This distribution is quite similar to that of the racial composition of the city of Chicago during the interval of this study.

It is of interest that the place of birth of the patients from the south in this series was found to be Alabama and the Appalachian states more frequently than Mississippi. Mississippi has been the most important source of black migrants to Chicago in recent years, whereas many whites have come from Alabama and the Appalachian area.<sup>7</sup> There was an equal distribution of the M.C.D.H. infections by sex; 40 of the patients were females and 38 were males.

Eleven of the cases seen at M.C.D.H. had complicated clinical courses. (Table 6) The most frequent and ominous complication was myocarditis, which occurred in seven patients. All three of the patients who had a fatal outcome developed diffuse myocarditis with major conduction defects and cardiac failure.

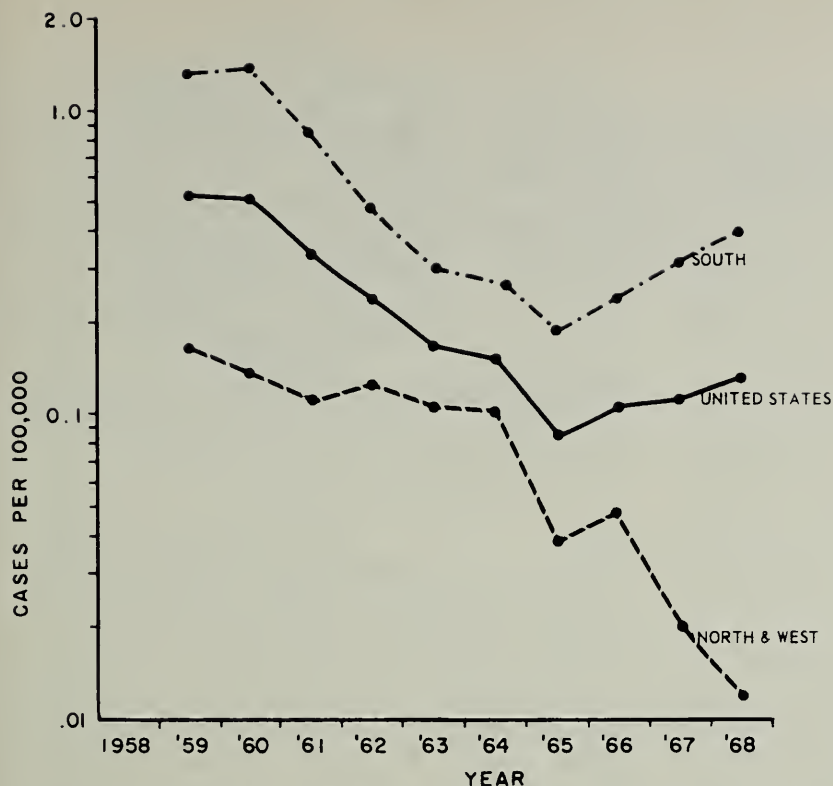
**Table 6**

**Complications of diphtheria among 38 patients seen at the Municipal Contagious Disease Hospital 1960-1970.**

Complication	Number of patients	Percent of patients
Absent	27	71.0%
Present	11	29.0%
Deaths	3	7.9%
Myocarditis	7	18.4%
Pneumonia	2	5.3%
Otitis Media	2	5.3%
Acute Nephritis	1	2.6%
Guillain-Barre Syndrome	1	2.6%

#### Comment

The recent outbreak of diphtheria in Chicago (which has been reported in a previous issue of the *Illinois Medical Journal*<sup>8</sup>) together with the recent national experience indicate this disease is still an important medical and public health



**Fig. 5. Diphtheria rates by year and region in the United States, 1959-1967.**

problem. The progressive yearly decline in the number of reported cases in the United States that began in the early 1920's was interrupted in 1965. Each year, since that time, there has been a slight increase in the number of reported cases. Most of this recent increase has been related to an increase in cases from the Southern United States. (Fig. 5) In addition to the outbreak in Chicago, other areas of the country have also experienced outbreaks recently. Most of these outbreaks have occurred in the Southern part of the country. The largest of the outbreaks involved 96 persons in San Antonio, Texas.

The recent outbreak in Austin, Texas was epidemiologically similar in many respects to the endemic disease activity in Chicago in 1960-1969 and the outbreak in Chicago in 1970. In each of these circumstances the disease involved predominately unimmunized or poorly immunized children from the lower socio-economic segments of the population. There were no direct contacts between most of the cases involved in either the Chicago or Austin outbreaks. Instead, these outbreaks represented several foci of cases occurring at an increased rate among the unimmunized children living in areas where immunization levels were generally low and endemic diphtheria had been present for a number of years. When cultures were obtained from contacts, asymptomatic carriers of *C. diphtheriae*

were often detected from household, classroom or other close contacts.

These carriers, as a group, had much better immunization levels than the cases and probably played a role in dissemination of the disease. In the Austin outbreak, the carrier state was detected in 14.1% of contacts of cases and in 9.8% of the total number (2,329) of residents who were cultured for diphtheria. One of the adult "endemic" carriers admitted to M.C.D.H. was known to be an intermittent carrier for at least 1½ years. One small outbreak seen at M.C.D.H. is illustrative of the possible importance of asymptomatic carriers in maintaining foci of diphtheria and spreading infection to susceptible subjects who are poorly immunized.

The first case in this outbreak occurred in a 12-year-old who gave a history of 1 D.P.T. immunization. He developed a sore throat and ear ache three weeks prior to admission to M.C.D.H. He was seen after one week at a Chicago Hospital emergency room and given penicillin. His symptoms improved temporarily but recurred 1½ weeks later. He was discovered to have diphtheria on admission to M.C.D.H. The patient's 4-year-old brother was admitted later that same day with a membranous pharyngitis and bull neck. Toxigenic *C. diphtheriae* was recovered from both patients and they were treated with antitoxin, penicillin and erythromycin. They were discharged about a month later after they made a satisfactory recovery and had four negative pharyngeal cultures for *C. diphtheriae*. Cultures of the household contacts were negative for *C. diphtheriae*. Six weeks later their 6-year-old sister, who had complete immunization, was admitted with membranous diphtheria. The index family had moved to a different address by this time. However one month after the six-year-old had been admitted, another case of diphtheria occurred in a 12-year-old who had been living in the same apartment building in which the family had previously lived when the two became ill.

Although the source for the last case was not identified, it would seem likely that a carrier



who was undetected by the epidemiological investigation was involved.

In general, only mild disease or a carrier state results when an infection occurs in a person who is completely immunized. There are rare exceptions, however. In our series one fatality occurred in a person who had been completely immunized. Two of the 24 fatal cases with known immunization status reported to the U.S. Public Health Service, Center for Disease Control in 1968, occurred in persons with histories of complete immunization.<sup>9</sup>

Analysis of the place of birth of our infected patients and their parents disclosed a marked concentration of cases among persons whose family came from the Southern United States or Puerto Rico. In fact only 14 of the 76 infected persons were from Chicago or the Northern United States when the place of birth of the patient and parents were known. During the last decade 85-95% of all diphtheria cases that were reported to the U.S. Public Health Service occurred in the Southern United States. In 1967, the highest attack rate of any state was 1.50 cases per 100,000 population in Louisiana. Alabama and Texas had rates of 0.62 and 0.60 respectively.<sup>10</sup> The mean annual residence of diphtheria in the Uptown area of Chicago between 1960 and 1970 was 1.57 per 100,000 population. The migration rate from the Southern United States to the Uptown area and the other Chicago community areas of high diphtheria incidence has been relatively great in the past decade. These foci are the result of the combination of many factors such as a relatively low prevalence of complete immunization, the more frequent presence of the organism in the throats of carriers or cases, and the many faceted environmental problems associated with poverty, such as household crowding and poor nutrition in areas of Chicago with large numbers of recent migrants from the Southern United States.

When clinical diphtheria occurs it is still a very serious disease. The national data and that from Illinois indicate that the case fatality ratio is still about 10%. This ratio has remained relatively unchanged since the incidence of the disease began to decline in the early 1920's. (Fig. 6) It is of interest that such a marked difference exists in case fatality rates between M.C. D.H. and cases reported from elsewhere in the city of Chicago.

Therefore, it is incumbent upon the physician who sees cases of pharyngitis to keep diphtheria in mind, even in patients with histories of immunizations residing in low risk areas. Recently such a patient was seen from suburban Cook

County who proved to have acute diphtheria.

Diphtheria is a clinical diagnosis and one usually cannot wait for laboratory confirmation before initiating antitoxin treatment. The death rate almost doubles for each day antitoxin treatment is delayed, and if therapy is delayed beyond the sixth day of disease there may be no improvement in the death rate.<sup>11</sup> Additionally, there is a marked increase in toxin associated complications with each day of delay in therapy. Antitoxin treatment at the time of clinical diagnosis implies that some patients who ultimately are proven to have other diseases will be treated with antitoxin. The risk from such treatment is less than the risk from failure to treat diphtheria.

Antibiotic treatment before adequate cultures have been taken may prevent bacteriologic confirmation and may not interrupt the cycle of bacterial growth, toxin production and membrane formation.<sup>11,12</sup> Erythromycin is probably the best antibiotic for eradicating *C. diphtheriae* from persons with positive cultures. A 10% failure rate has been reported recently using penicillin.<sup>5</sup> The organisms were eradicated from all of these patients with erythromycin.

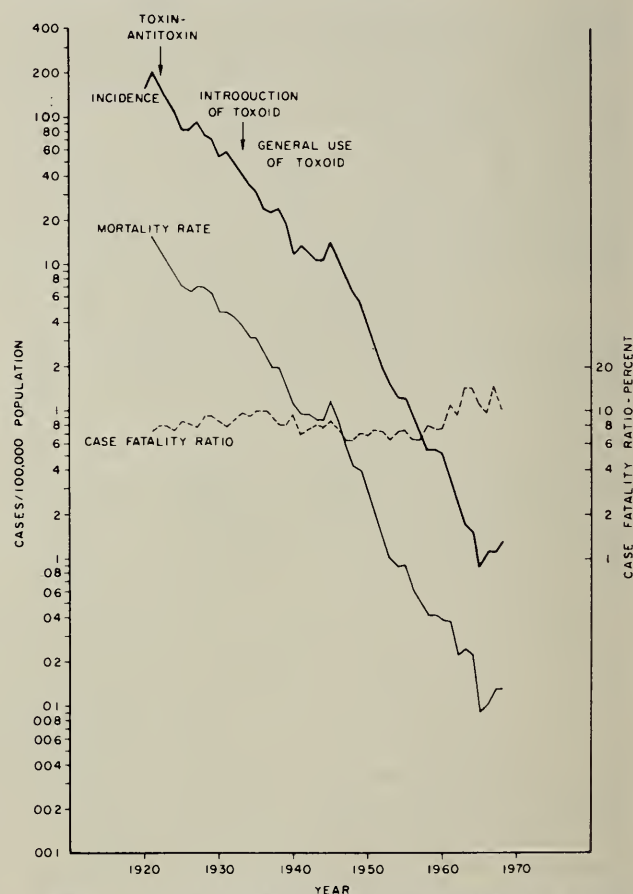


Fig. 6. Annual incidence and mortality rates; and case fatality ratio of diphtheria in the United States, 1920-1968.

(Continued on page 88)



# socio-economic news

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a service of the division of public relations and economics

By JOSEPH LOTHARIUS

## **BOARD ASKED TO O.K. HEALTH CARE FOUNDATIONS**

Foundations for Medical Care took a giant step toward becoming a reality in Illinois when ISMS's Committee on Health Care Financing agreed to recommend the establishment of a non-profit corporation (FMC) sponsored by ISMS. The Committee made its decision after months of careful deliberation and many discussions with national experts in this field. The recommendation will be considered by the Board of Trustees in January. According to the Committee's recommendation, the Corporation would cooperate with prepayment plans, insurance carriers, government agencies and others in providing health care, with the further objective of meeting the requirements of a professional service review organization (PSRO) and other appropriate health care delivery systems established by law. The Corporation would be organized in compliance with all legal requirements and provide for full autonomous participation by local medical societies or groups of medical societies.

## **RECORD ATTENDANCE AT LEADERSHIP CONFERENCE**

A record-breaking turnout of ISMS members attended the special Leadership Conference to hear the "experts" discuss the various major health care delivery systems that are being proposed. One of these systems or a combination of several may be the future method by which medicine is practiced in Illinois. More than 425 physicians and medical personnel from all parts of the state heard Dr. Roger Egeberg, assistant secretary of HEW, stress the urgency for changing present modes of health care. Emory Bullis, assistant to the director of HEW, described HMO's (Health Maintenance Organizations). The merits of foundations for medical care programs were discussed by Dr. Donald Harrington, medical director of the San Joaquin Foundation for Medical Care, Louis A. Orsini, director of the Health Insurance Council, and Dr. Richard E. Anonsen, president, Hennepin County (Minnesota) Health Care Foundation. Condensed versions of each presentation can be found beginning on page 53. A detailed comparison between two kinds of Foundations for Medical Care appears in the January issue of *PULSE*.

## **IDPA COMMITTEE REJECTS REQUEST**

Permission for groups and/or clinics to sign IDPA claim forms was not recommended by the Medical Advisory Com-



### **IDPA WILL LIMIT PAYMENT TO HOSPITALS**

### **LEGAL IMMUNITY ASKED FOR PEER REVIEW COMMITTEES**

mittee to IDPA. The Committee had been requested to consider an ISMS resolution asking IDPA to allow persons other than the physician involved to sign the claim forms. It was felt by Committee members that the present IDPA policy forcing physicians to personally sign their own claim forms should remain unchanged *except for those groups or clinics receiving prior approval from the Committee.*

IDPA will inform local hospitals of a cut-off date for payments on terminally ill patients in those cases where the Department thinks the patient could receive adequate care in an extended care facility or nursing home. The Medical Advisory Committee to IDPA thought this policy should be adopted even though local utilization review committees might disagree and uphold the admitting physician. In the event of such disagreement, IDPA WILL submit the case to the appropriate peer review committee.

Legal immunity for physicians serving on peer review committees is being urged by ISMS' Council on Economics & Peer Review. The Council has asked the Board of Trustees to encourage legislation which would provide a physician who serves on a review committee immunity from litigation arising from the actions of that committee. Such action closely follows an AMA endorsed resolution asking every state to adopt protective legislation for peer review committee members.

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## **Hypochondriacal patient in the doctor's office**

*(Continued from page 69)*

ond nature to him. Then, once he has begun to talk about his loneliness and his entirely egocentric world you have to start suggesting to him a re-entry into that world which he believes has rejected him—although the fact is that he has rejected the world. You must examine his interests, his skills, his aptitudes and his potentialities.

You might have to tell him to attempt to re-establish family relationships. Tell him to send a birthday card to someone; call to say "how are you;" invite someone to a meal; or stage a little get-together party—even if it means humbling himself in the face of real or imagined wrongs.

It may take several sessions of discussion to get this one worked out, but surely it would be a change from hearing eternally about "my poor digestion, my weak kidneys, my bad back." You have to suggest re-socialization—he should talk to his minister about church activities he might attend, or investigate community center ac-

tivities. He might even meet a friendly human being at a ball park or a race track. He might talk to somebody at one of the agencies about a job or a change of job.

In summary:

1. Refuse to listen to his medical complaints.
2. Show evident interest in the patient's personal and inter-personal emotional discontents.
3. Demonstrate patience and tolerance, and establish a rigid routine designed to prove to the patient that you do care, and do want him there regularly to absorb the type of attention you are prepared to devote to him.
4. Use no sedatives, no tranquilizers, no vitamins, and *no* placebos—and above all—no instruments.

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*Postgraduate Course*

"Complications of Angiography & Other Special Procedures & Their Legal Implications"

2020 E. 93 St., Cleveland, Ohio

### Feb. 1-5—University of Chicago

*Tutorial on Neoplastic Hematopathology for the Practicing Pathologist*

1307 E. 60 St., Chicago

### Feb. 3-4—Cleveland Clinic Educational Foundation

*Postgraduate Course*

"General Practice"

2020 E. 93 St., Cleveland, Ohio

### Feb. 3-7—American College of Cardiology

*20th Annual Scientific Session*

Sheraton-Park Hotel, Washington, D.C.

### Feb. 10-11—Cleveland Clinic Educational Foundation

*Postgraduate Course*

"Disorders of the Red Cell"

2020 E. 93 St., Cleveland, Ohio

### Feb. 14-18—Medical Society of the State of New York

*Annual Convention*

Americana Hotel, New York City

### Feb. 14-20—University of Kentucky

*Postgraduate Course*

"General Practice Review"

### Feb. 16—American College of Surgeons Committee on Trauma

*"Musculo-Skeletal and General Surgery Trauma"*

1835 W. Harrison, Chicago

### Feb. 19-20—University of Wisconsin

*Symposium*

"Perils of Medical Management"

Dept. of Postgraduate Medicine, Madison, Wisconsin

### Feb. 16-19—University of Iowa

*Conference for Family Practitioners*

University of Iowa, Medical Research Center, Iowa City, Iowa

### Feb. 20-21—American Academy of Allergy

*Postgraduate Course in conjunction with 27th Annual Meeting*

Palmer House Hotel, Chicago



## Diphtheria in Chicago

(Continued from page 80)

It is also extremely important that the physician report each such case of diphtheria to the Health Department. In most instances the practicing physician is rarely in a position to do a thorough epidemiological investigation. Other cases or carriers will be discovered upon investigation of the household, classroom or other close contacts. If carriers are detected it is important that they also be treated with antibiotics since they may be capable of spreading this infection to other susceptibles. If a suspected diphtheria patient received antibiotics prior to culture, then the family should be cultured as a method of confirming the diagnosis of diphtheria.

The most important ingredient in the control of diphtheria is immunization of all susceptible persons with diphtheria toxoid, especially those in high risk areas. Following the 1970, Chicago diphtheria outbreak, over 200,000 doses of toxoid were given in mass immunization clinics. Similar efforts have been made in Austin, San Antonio, Miami and other areas that were having epidemics of disease. A survey was done to determine the immunization status of the population after a mass campaign in Austin, Texas. It was found that although the levels of immunization of school-aged children were improved considerably during this mass campaign, the level of complete immunization among pre-school children was raised from 54% to only 60%.

The levels of immunity necessary to prevent the spread of diphtheria are unknown. It has been estimated that in densely populated urban areas at least 70% of the school and pre-school age children must be immunized to prevent the spread of diphtheria.<sup>13</sup> Nevertheless, the epidemic in Austin continued even after the levels in school children had been raised to above 80%.<sup>5</sup> Also, other outbreaks of diphtheria have occurred among inadequately immunized persons in well-immunized groups.<sup>13-18</sup>

### Summary

Diphtheria is still an important public health problem in Chicago. Analysis of the reported cases in Chicago between 1960 and November 30, 1970 indicated that most of the cases occurred among unimmunized or incompletely immunized children and adolescents. The frequency of infection was greatest among persons living on the North Side of the city, next on the West Side and least frequent on the South Side. The rates were highest in the Uptown Community area and they were similar in this area to that reported from the Southern states that have the

highest incidence. The majority of the cases seen at the Municipal Contagious Disease Hospital had families from the Southern United States.

When clinical diphtheria occurs the consequence remains serious. The case fatality ratio in Chicago during the period of this study was 16.1%. This is slightly higher than the officially reported mortality rates in this country for the past four decades.

Carriers, when detected, often occurred among immunized children or adults. Asymptomatic carriers may have a significant role in the maintenance of endemic foci. When combined with an inadequately immunized group in the population, this could have led to a stable geographic focus in which repeated, apparently unrelated, outbreaks occurred.

It is essential for the control of diphtheria in Illinois that physicians first consider the diagnosis and then report all cases that are diagnosed so that an epidemiological investigation can be done.

The critical need, however, is for more complete protection of the population, especially those living in high risk areas, with diphtheria toxoid. ◀

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(Continued on page 98)

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## Problems of ECF program discussed

Ernest A. Adams, M.D., medical consultant for Aetna Life & Casualty Company, Peoria, and Mr. Thomas B. Keener, administrator, Medicare Claims Administration, Aetna Life & Casualty attended the November meeting of the Committee on Aging to discuss problems in the Extended Care Facility (ECF) program under Medicare, especially retroactive denial of benefits for which physicians often get blamed.

Dr. Adams said the biggest problem in the ECF (and other portions) of the Medicare is one of communications. He presented the Medicare "Assurance of Payment Provision" as an example:

This assures coverage from the day a patient is transferred from a hospital to an ECF-certified facility until a final decision is made on the patient's claim. *But coverage is allowed only if the carrier receives an "Admission Transmittal Notice" postmarked within 48 hours of patient admittance to the ECF.* Medical information required for the two-page form is usually covered in the hospital transfer form, hospital discharge summary, and the physician's orders for the patient. When such information is given to the nursing home at time of admittance, the form can be filled out and sent to the carrier, assuring coverage. The carrier also takes weekends and holidays into consideration on the "48-hour deadline."

In some cases, Dr. Adams said, the nursing home receives no medical information. One patient was in an ECF for five days before he was seen by his physician. The nursing home staff, in the absence of a physician's order, continued the prescriptions the patient brought with him. "This same doctor then gets on the phone and demands to know why the patient isn't covered. We didn't even know the patient had been admitted to an ECF." Providing adequate information at time of admission not only assures coverage until a claims decision is made, but guarantees the patient the skilled nursing care to which he's entitled, Dr. Adams said.

Dr. Adams said that Utilization Review Committees have been invaluable in making sure cooperative agreements exist between hospitals and ECFs to make a smooth transfer of such information along with the patient. *The physician attending need not be involved other than providing orders for the patient.*

Dr. Adams, citing the "once a month visit by the physician" requirement, added that follow-up progress notes by the physician are often inadequate, as well as daily nursing notes. "So we have cases where initial information, as well as follow-up information, is totally inadequate to establish a claim for the patient," Dr. Adams said.

The Aetna representatives replied that progress and nursing notes need not be extensive, but that they must be medically descriptive.

"We are here to serve the needs of the patient, but the physicians must tell us what those needs are," Dr. Adams added. He agreed that Medicare regulations are bothersome, but that the insurance carrier, as well as the physician, have no choice but to live by them until something better comes along.

It was pointed out that skilled nursing care can be an important adjunct to a patient's health, and that when provisions for such care are dismissed as "tiresome regulations," the patient and his family are the ones who are hurt.

Members of the committee asked if a patient's eligibility for ECF benefits, when denied because of a lack of information, could be retroactively re-established. Mr. Keener replied that they often can, if the physician reconstructs the medical necessity by reviewing his records. When such reviews are requested, they go through the Social Security Administration for approval.

Mr. Keener also emphasized that an ECF can hire an office employee to supervise handling of Medicare records, and that the overhead costs of hiring such an employee are chargeable to Medicare expenses. ◀

# Rx Product Index

<i>Achrostatin</i> .....	93
Lederle Laboratories	
<i>Antrocol</i> .....	8
Wm. P. Poythress & Co., Inc.	
<i>Alpha Keri</i> .....	91
Westwood Pharmaceuticals, Inc.	
<i>Aventyl HCL</i> .....	22-24
<i>Ilosone</i> .....	34
Eli Lilly and Company	
<i>Dicarbosil</i> .....	98
Arch Laboratories	
<i>Empirin Compound w/Codeine</i> .....	33
Burroughs Wellcome & Co.	
<i>Hygroton</i> .....	85
Geigy Pharmaceutical Corp.	
<i>Larobec</i> .....	30-31
<i>Librium</i> .....	18-19
<i>Menrium</i> .....	6-7
<i>Noludar</i> .....	89, 97
<i>Valium</i> .....	Back Cover
Roche Laboratories Div., Hoffmann-LaRoche, Inc.	
<i>Lomotil</i> .....	2nd Cover, 1
G. D. Searle & Co.	
<i>Kantrex</i> .....	3rd Cover
<i>Salutensin</i> .....	20-21
<i>Tetrex b.i.d. Caps</i> .....	86-87
Bristol Laboratories	
<i>Mylanta</i> .....	2
Stuart Pharmaceuticals Div., Atlas Chemical Industries, Inc.	
<i>Silain-Gel</i> .....	28-29
A. H. Robins Co., Inc.	
<i>Sinequan</i> .....	11-14
Pfizer Laboratories Div., Pfizer Inc.	
<i>Tepanil/Quinamm</i> .....	15, 16
<i>Orenzyme/AVC</i> .....	81, 82
National Drug Company	
<i>Vasodilan CVD</i> .....	4-5
Mead Johnson Laboratories	



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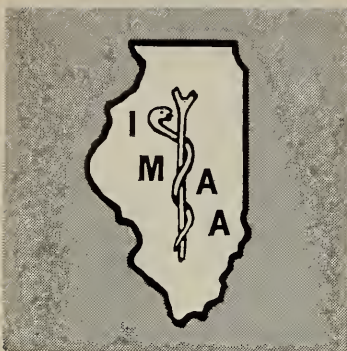
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## report

a service of the illinois medical assistants association

### *Medical assistant must maintain perfection*

By RUBY JACKSON/CHICAGO

The Illinois Medical Assistants Association believes the qualifications for a Medical Assistant are the same as for any other position: intelligence, dependability, accuracy, tact, willingness to learn, adaptability and an interest in people, not necessarily in that order. However, while accuracy is important in any office or business it is doubly so in the medical office because human life and health are at stake.

The Medical Assistant has a multiple role. She must assist with patients, prepare medications and if a nurse, often administer medications, do laboratory tests, handle correspondence, bookkeeping, telephone calls and visits from salesmen and pharmaceutical representatives. Accuracy plays an important part in all of these various roles. Accurate spellings of names, ages, addresses and phone numbers must be obtained at the first visit and changes should be noted promptly on all records. Accuracy in laboratory tests is obviously important since the doctor's entire plan of treatment may be based on the laboratory findings and life and health may be involved.

Appointments should be taken in order to avoid offending patients, the one exception to this rule is the occasional emergency which takes precedence over everything else.

Mail should be opened daily and handled im-

mediately, not allowed to accumulate. Checks should be recorded promptly and credited to the proper account. All bills offering a discount for prompt payment should be paid first. Reports to insurance companies or to attorneys must have correct facts regarding dates, sex and medical fees to avoid irritation of patient or insurance company. Both a regular and a medical dictionary should be in every office.

Perfection is probably unattainable, but by constant alertness and effort accuracy can be improved and brought to a satisfactory level. Perfection should always be striven for, so that high levels of accurate performance may be arrived at and maintained.

Illinois Medical Assistants Association urges all Medical Assistants to evaluate themselves at intervals to increase their accuracy. At the monthly meetings of your county chapter talented people will help you learn of new methods, new machines and new ways to do the usual and customary jobs to make your office more efficient and effective. If you are not already a member of Illinois Medical Assistants Association plan to attend a few meetings to see what you are missing.

For more information contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Illinois 60451 or Mrs. Vivian Kraft, R.R. No. 2, Normal, Illinois 61761.

---

### **No Demise for the Economy**

"This nation is just as fundamentally healthy today as it has ever been. Whatever the future may hold on the specific problems and policies of our times, I want to reassure you that we are not going to preside over the collapse of our system."—Secretary of Commerce Maurice H. Stans.

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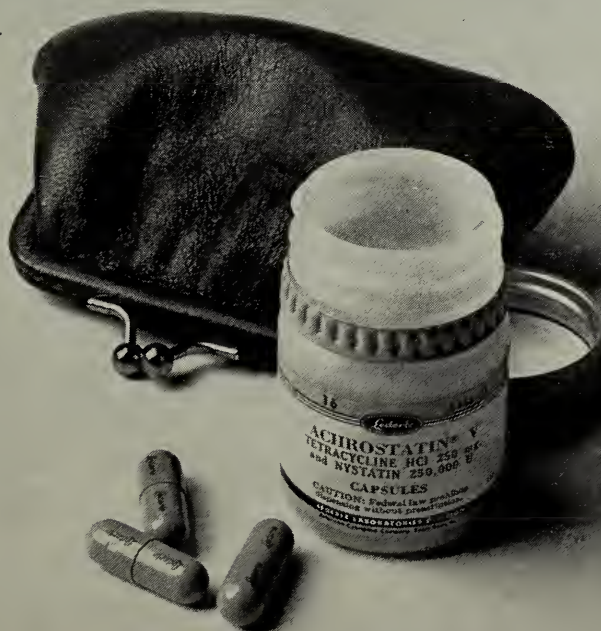
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## *Clinics for Crippled Children scheduled*

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will hold 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Feb. 3—Rock Island Cerebral Palsy — 3808 Eighth Avenue
- Feb. 3—Carlinville—Carlinville Area Hospital
- Feb. 3—Hinsdale—Hinsdale Sanitarium
- Feb. 4—Sterling—Community General Hospital
- Feb. 9—East St. Louis—Christian Welfare Hospital
- Feb. 9—Peoria—St. Francis Children's Hospital
- Feb. 10—Champaign-Urbana — McKinley Hospital
- Feb. 11—Springfield—St. John's Hospital
- Feb. 11—Rockford—St. Anthony Hospital
- Feb. 11—Lake County Cardiac—Victory Memorial Hospital
- Feb. 12—Chicago Heights Cardiac—St. James Hospital
- Feb. 16—Belleville—St. Elizabeth's Hospital
- Feb. 16—Rock Island Area General—Moline Public Hospital

- Feb. 17—Chicago Heights General—St. James Hospital
- Feb. 18—Anna—Union County Hospital
- Feb. 18—Bloomington—Mennonite Hospital
- Feb. 18—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Feb. 22—Peoria Cardiac—St. Francis Children's Hospital
- Feb. 23—Danville—Lake View Hospital
- Feb. 23—Peoria—St. Francis Children's Hospital
- Feb. 24—Springfield Pediatric Neurological—Diocesan Center
- Feb. 24—Aurora—Copley Memorial Hospital
- Feb. 24—Hinsdale—Hinsdale Sanitarium
- Feb. 26—Chicago Heights Cardiac—St. James Hospital
- Feb. 26—Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

---

## Obituaries

\***Benjamin B. Berman**, Granite City, died Nov. 3 at the age of 55. He was past president of the Madison County Medical Society.

\***Virgil O. Decker**, Metropolis, died Oct. 26 at the age of 69. He was past president of the Massac County Medical Society.

\***John D. Hardinger**, Mattoon, died Oct. 29 at the age of 53.

\***John F. Kluzak**, Broadview, died Nov. 21 at the age of 78. He was treasurer of the Doctors' Association at Oak Park Hospital.

\***Walter H. Milbacker**, Aurora, died Nov. 15 at the age of 68.

\***John D. MacKellar**, Santa Barbara, Calif., died Dec. 7 at the age of 89. He was former head of the Jenner Medical College in Chicago before retiring. He was a member of the ISMS Fifty-Year Club.

\***Holland Williamson**, Danville, died Oct. 25 at the age of 70. He was past president and past secretary of the Vermilion County Medical Society.

*\*Indicates member of the Illinois State Medical Society.*

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J. Dennis Freund, M.D., Medical Director

## Viewbox

*(Continued from page 40)*

### **Diagnosis: 2. Neuroblastoma**

Neuroblastomas may occur in any location in the body when neural crest tissue exists embryologically. Therefore, such tumors are most often found along the sympathetic chain ganglia from the neck to the pelvis especially in or near the adrenal medulla where concentrations of sympatheticoblasts are greatest. The tumors may be either extremely malignant or have a more benign form.

Neuroblastomas frequently are not encapsulated tumors and they metastasize to bone (see Fig. 2), the skull, to the retro-orbital areas, to the liver and by direct extension into adjacent organs. It is extremely rare for neuroblastoma to metastasize to lung paranchyma.

Calcium is frequently present in the neuroblastoma and is usually described as being finely scattered within the lesion, however it does not have to be present; when it occurs, it is thought to be due to necrosis and calcification.

The IVP in this case shows a downward displacement of the right kidney which shows no invasion of the calyces or the pelvis. The mass is above the kidney and displaces the kidney downward. In a Wilm's tumor we would see considerable displacement of the pelvo-calyceal system in the usual case, as the tumor is intrarenal in nature. Because neuroblastomas occur anywhere up and down the sympathetic chain, they will be found in the abdomen, in the region of the adrenal gland, or all the way down into the pelvis. They may be along the chain of the aorta and will show ureteral displacement and no renal displacement. Some neuroblastomas produce hypertension and increased excretion of catechol amines. The excretion of VMA may be increased particularly in the urine in the presence of neuroblastomas. ◀

### **Reference**

Hope, J. W., Borns, P. F., and Koop, C. C., "Diagnosis in Treatment of Neuroblastoma and Embryoma of the Kidney," *J. Radiol. Clinics of No. Amer.*, Volume 1, No. 3, December, 1963.

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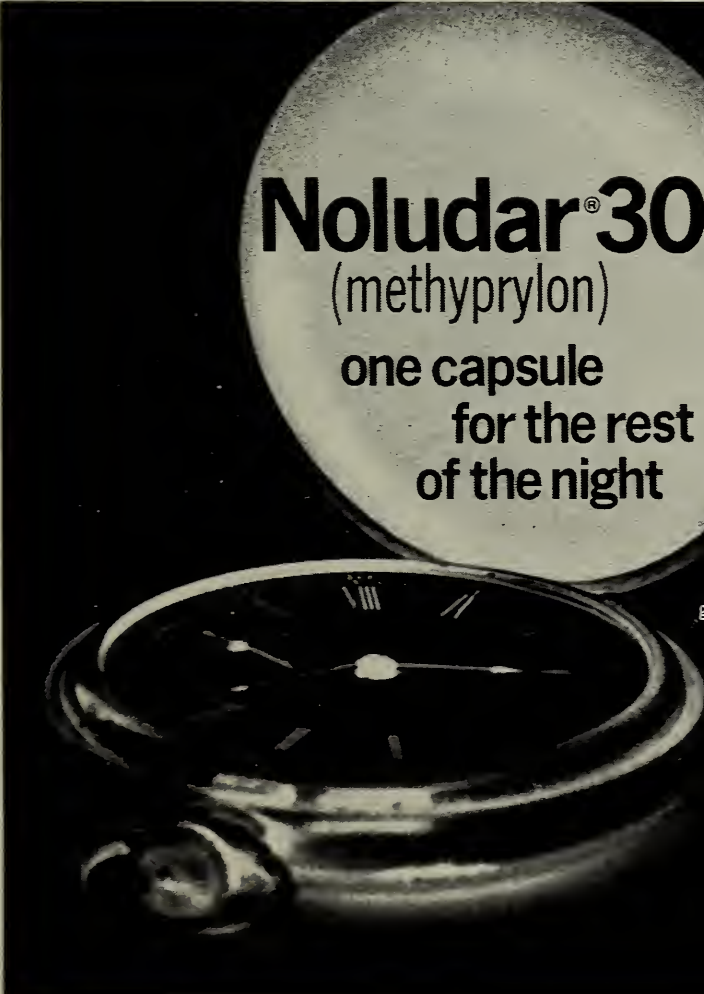
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**Physical and Psychological Dependence:** Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

**Usage in Pregnancy:** Weigh potential benefits in pregnancy, during lactation, or in women of child-bearing age against possible hazards to mother and child.

**PRECAUTIONS:** If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

**ADVERSE REACTIONS:** At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.



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NEWER TECHNIQS IN UROLOGY INSTRUMENTATION, One Day, Mar. 15  
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VAGINAL APPROACH TO PELVIC SURGERY, One Week, Feb. 1  
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## ECG

(Continued from page 48)

### Answers

1. B, C and D. The electrocardiogram discloses the R-R intervals to be variable from beat to beat. No P waves are seen. The baseline is uneven and atrial activity is represented by irregular durations or "f" waves. These have great amplitude in V<sub>1</sub> and V<sub>2</sub> characteristic of activity generated by an enlarged Lt. atrium. The ST and T segment changes are nonspecific but may be due (at least in part) to digitalis effect.
2. C. The physical findings described are classic for mitral insufficiency. The sudden change in the severity of the patient's symptoms occurring 24 hours prior to admission probably heralded the onset of her cardiac arrhythmia.

## Diphtheria

(Continued from page 88)

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## Group practice

(Continued from page 27)

program in effect, it will be illegal for any physician or other health service provider to have any financial dealing with a patient or even to offer his services outside the government scheme. Fees will be set unilaterally by the government and even the historic responsibility for physician discipline will be taken over by the new government committee."

Gentlemen, we must not allow this to happen in Illinois.

*J. Ernest Breed M.D.*



# illinois medical journal

volume 139, number 2

February, 1971

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clinical  
articles

Tubal pregnancy in a patient with an IUD <i>Vincent S. DiGiulio, M.D., F.A.C.O.G., F.A.C.S.</i> .....	131
Hypertension and duodenal ulcer Associated with pneumocystis carinii pneumonitis and dysgammaglobulinemia <i>Enrico T. Farinas, M.D., and Jorge A. Quel, M.D.</i> .....	138
A new approach to the management of refractory psoriasis <i>J. W. Yarbrow, M.D., Ph.D. and Ullin W. Leavell, Jr., M.D.</i> .....	152

surgical grand rounds	Hydronephrosis .....	134
-----------------------------	----------------------	-----

surgical progress	The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease <i>E. Richard Blonsky, M.D.</i> .....	144
----------------------	--	-----

special articles	Expansion of a local effort	
	The MECO Project	
	Lee A. Fischer .....	155
	The “art” of medicine	
	J. Ernest Breed, M.D., ISMS President .....	159
	The doctor as a target in malpractice	
	Herman Wing, M.D., LL.B. ....	162

features	the president's page .....	115
	the view box .....	132
	ekg of the month .....	143
	medical legal review .....	167
	editorials .....	170
	socio-economic news .....	180
	practice management .....	190
	What goes on .....	174

(Cover story on page 126)

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Original articles will be considered for publication with the understanding that they are contributed only to the Illinois Medical Journal. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

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# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### Blue Shield Booth at CMS Clinical Conference

Blue Shield invites you to visit its booth in the McCormick Place during the Clinical Conference of the Chicago Medical Society, March 3-6.

The booth will be staffed by Professional Relations Representatives of our Plan qualified to answer questions pertaining to our Blue Shield operations in general and Medicare in particular.

Literature will be available pertaining to our Usual and Customary Plan which became effective in 1967 following approval of the State Society's House of Delegates to apply the Society's definitions of Usual, Customary, and Reasonable to new Blue Shield accounts and to make payments to physicians on that basis.

We will also have literature available pertaining to our new Blue Cross 65 Blue Shield 65 program.

When Medicare became effective July 1, 1966, and Blue Shield was appointed Part B carrier for the counties of Cook, DuPage, Kane, Lake, and Will, we broadened our communications effort to keep physicians and their office assistants informed of ongoing changes with respect to covered services, processing, and information we need to speed payments to physicians who accept assignments or to patients whose physicians bill them directly.

We have staff available to make personal calls to your office and to assist you or your office assistant in preparing our Blue Shield Physician's Service Report or assist you in other matters pertaining to our overall operation.

When visiting the exhibit area during the Clinical Conference, make it a point to stop at our Blue Shield booth #58 and meet our representatives; let them describe our services to you; and let us know how we can serve you better.

### Dinner Workshops for Medical Assistants Scheduled

The Blue Shield Plan of Illinois Medical Service will hold dinner workshops for Medical Assistants in the area we serve to help keep them abreast of changes in Blue Shield procedures, benefit structures, and methods.

Starting in April dinner workshops will be held for Medical Assistants in the central and southern counties of Illinois. All Medical Assistants are invited to attend. Following dinner, executives of the Plan will discuss matters relating to Blue Shield operations and will answer questions relating to Blue Shield activities.

The dinner workshops are scheduled as follows:

April 1	—	Ramada Inn	Effingham
April 14	—	Hyatt House	Belleville
April 15	—	Holiday Inn	Edwardsville
April 28	—	Ramada Inn	Mt. Vernon
April 29	—	Ramada Inn	Marion
May 5	—	Ramada Inn	Champaign
May 12	—	Ranch House	Bureau
May 13	—	Ramada Inn	Kankakee
May 26	—	Decatur Club	Decatur
May 27	—	U.S. Grant Motor Inn	Mattoon

Twenty meetings were recently concluded in the northern counties which were attended by about 4,000 Medical Assistants. The Assistants informed us that the meetings were instructive and helpful to them in carrying out their responsibilities for their physician-employers.

Medical Assistants and physicians who have questions regarding the Physician's Service Report form or other Blue Shield matters may contact the Professional Relations Department, 222 North Dearborn, Chicago, Illinois 60601.

### Reporting Services of Out-of-State Members

When you submit claims for your services provided to out-of-state Blue Shield members, please complete our regular Blue Shield *Physician's Service Report* form and list the dates of service, the services performed, and your fee for *each* service. Mail completed forms directly to the Blue Shield Plan listed on the identification card of your patient.

Each Blue Shield Plan processes claims for its own members and undue delays in payment can be avoided by mailing completed Report forms directly to the Plan involved.



## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

## Inpatient Certification and Recertification

The Social Security Administration has notified all Medicare Intermediaries of changes in regulations governing certification and recertification of inpatient care for Medicare beneficiaries.

Payment can be made for covered hospital services but only when the physician certifies that the services are medically necessary. Physician certification and recertification statements should be retained in hospitals' files where they may be verified by the intermediary whenever necessary.

Since January 1st of this year it has been necessary to make the first certification by the 12th day of the patient's hospitalization. The Social Security Administration requires the first recertification as of the 18th day of hospitalization. Medicare regulations further require subsequent recertification to be made at intervals established by the hospital's utilization review committee but not to exceed 30 days.

Medicare regulations make it necessary for certification and recertification records to contain:

1. an explanation of the medical necessity for continued hospitalization.
2. the estimated time the patient will have to remain in the hospital.
3. the plan for post-hospital care.

Certification and recertification must be signed by the attending physician or a member of the medical staff familiar with the case.

There is no requirement that certifications and recertifications be made on specific forms so long as the hospital record contains the above information and is available to the intermediary when requested.

*Recertifications* may be part of the utilization review plan but must include the information listed above which should be included in the minutes of the review committee.

If recertification is necessary at a time when the whole utilization review committee cannot meet, a subcommittee may be appointed to fulfill the Medicare requirement.

In the absence of documented physician certification and recertification for Medicare patients within the designated time payments to hospitals will not be made.

## Complete Information Needed

In order to speed Medicare payments, it is necessary to include detailed information on the Medicare "Request for Payment" Form 1490 or on an itemized statement attached to an SSA 1490 Form. When information is omitted, Medicare regulations require the carrier to obtain the necessary information. In Cook, Kane, Will, Lake and DuPage counties several hundred letters are mailed daily by Illinois Blue Shield to obtain additional information before the Medicare claim can be processed and paid.

The majority of these letters are mailed to obtain the following information:

- (1) Itemization of charges—  
Example: If during an office visit a C.B.C. is done, the Social Security Administration requires the charge indicated for the office visit and the C.B.C.;
- (2) Diagnosis;
- (3) Date each service was provided;
- (4) Length of time anesthesia was administered;
- (5) Extent, size and location of a lesion;
- (6) Location of a fracture and whether or not it was open or closed reduction;
- (7) Name the drug used for an injection and the charge;
- (8) Itemization of laboratory charges.

By including this information on your Medicare claim or itemized statements, you will help us to speed payments to you or to your patient.

## How to Request A Medical Review

Illinois Blue Shield as Part B Medicare Carrier in the five county area of Cook, Kane, Will, Lake and DuPage, has been informed by the Social Security Administration that all requests by physicians or beneficiaries to have a Medicare claim reviewed must be in writing. This may be done by letter to the Part B Medicare Carrier or by completing SSA Form 1964 which may be obtained from the Medicare office or from all Social Security offices. However, the written request must be within 6 months of the date indicated on the EOMB (Explanation of Medicare Benefits) form.

When requesting a review, please include additional information which you feel will be an aid in reviewing the claim. Also please include the case number and the date which appears in the upper right corner in the Explanation of Benefits form as they will help us in returning the results to you promptly.



## the presidents page

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# State control in planning for health facilities & services

### **The problem:**

The maldistribution of health care facilities such as hospitals, extended care units, shelter homes, etc., presents many problems. Where one hospital or nursing home is needed and can function efficiently, two competing facilities make it impossible for either to succeed.

The same holds true for special services requiring considerable investment, such as cobalt therapy, dialysis, isotope services or cardiac surgery. If every hospital were equipped to provide all of these services it is obvious that most of the time the equipment would stand idle.

### **Background:**

For years the Chicago Hospital Planning Council has served admirably in Cook County in recommending or discouraging new hospital construction. It conducted surveys which disclosed need or absence of need. Aside from moral suasion, however, the council has no real power to prevent the establishment of an unneeded facility.

The Illinois Department of Public Health has the power to prevent the building of a new fa-

cility only if it is insufficiently financed or if the promoters have unsavory reputations. The Department works through two groups—the Hospital Advisory Council, composed of 21 members with Franklin Yoder, M.D., director of the Department, as chairman. Presently the Advisory Council has four physicians, in addition to Doctor Yoder, one dentist and others representing different interests. Several hospital administrators are included. The other group is the Hospital Licensing Board which has nine members, with two physicians, one nurse, and the majority of the rest representing hospital management.

In the last Assembly the state authorities,

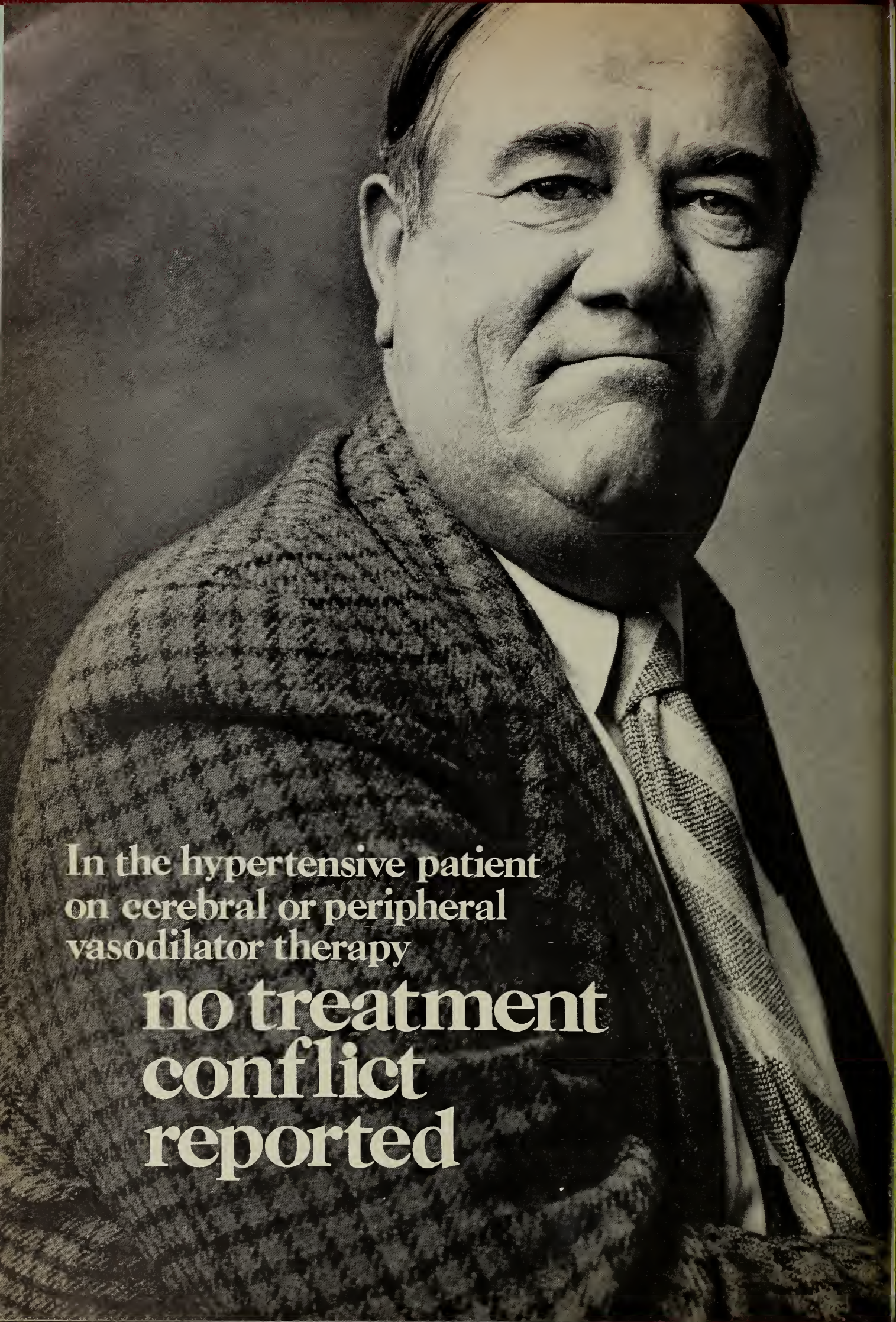
working with the Illinois Hospital Association and the Nursing Home Association, introduced a control bill in the Senate (S.B.-1145). This bill would have required a permit from the Illinois Department of Public Health before a hospital or nursing home could be built, enlarged or provide a new service. Only cursory consultation was requested from the Illinois State Medical Society and it seemed to us, undo haste was exercised to get the bill passed, so we opposed it and it was defeated.

### **A possible solution:**

It is obvious that an unnecessary duplication of medical facilities and services, to be paid for by the public, must somehow be discouraged. Recently, Doctor Yoder called a meeting of all interested groups. With the approval of several of the officers, Mr. Roger White, Executive Administrator of the Illinois State Medical Society, presented an outline for a new arrangement. It was emphasized that any plan for a new unit, whether a facility or service, should originate and be considered first by a local planning group, with the members aware of the need.

*(Continued on page 198)*





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## Obituaries

\***C. Jack Harrison**, River Forest, died Dec. 17 at the age of 67.

\***John F. Kluzak**, Broadview, died Nov. 25 at the age of 78. While on the staff of the Oak Park Hospital, he was treasurer of the doctor's association there.

\***Edward X. Link**, Mattoon, died Nov. 13. He was Coles County Coroner and Mattoon City Health Officer from 1941, until the time of his death. He was past president of the Coles-Cumberland County Medical Society. He was also a member of the ISMS Fifty-Year Club.

\***Arthur P. Martin**, Flossmoor, died Dec. 23 at the age of 76.

\***J. E. Marvel**, Waynesville, died Nov. 22 at the age of 86. He was a member of the ISMS Fifty-Year Club.

\***Clare Miller**, Des Plaines, died Dec. 26 at the age of 90. Dr. Miller was medical director of the Hillcrest Sanitarium in Quincy.

\***Julian L. Plaut**, Chicago, died in December at the age of 65. He was president of the medical staff at Jackson Park Hospital.

\***Frank M. Quinn**, Chicago, died Dec. 10 at the age of 61.

\***Nancy C. Treadwell**, Wilmette, died in December at the age of 46. She was an instructor at the University of Illinois College of Medicine.

\***Richard H. Young**, Wilmette, died in December at the age of 65. He was retired dean of the Northwestern University Medical School.

---

### Fourteen-point program

Have self-control.

Understand others' viewpoints.

Make others' interests your own.

Admit it when you're wrong.

Never make promises you can't keep.

Reason: don't argue.

Explain thoroughly.

Lead: don't drive.

Avoid snap judgments.

Take care of little things.

Inform people of changes affecting them.

Observe and listen.

Never criticize in public.

Stress the positive.

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### ON THE COVER

This month's cover depicts the normal hand and the palsied hand of the individual afflicted with Parkinson's disease. Dr. E. Richard Blonsky reports the role of the drug, L-DOPA, in treating parkinsonism victims beginning on page 144.

With the 131st Annual Meeting of ISMS only three months away, be sure and watch the ISMS publications for reports on what's happening this year at Convention, May 16-19 at the Arlington Park Towers, Arlington.

See page 178 for details on the "Physicians Art Exhibit" and an entry form. Scientific exhibits are still being accepted for the Annual Meeting, and an entry coupon can be found on page 191.

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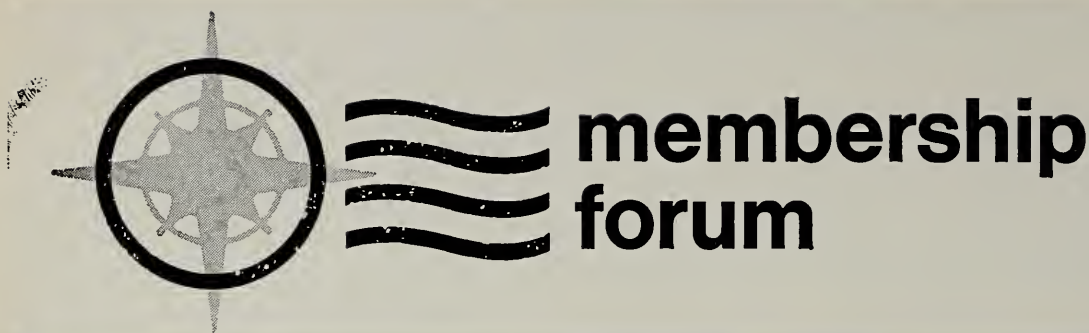


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## *Civil liability: more a myth than reality*

November 30, 1970

Dear Sir:

A summary of the "Good Samaritan Laws" presented on a state by state basis in the November, 1970 issue of the *Illinois Medical Journal* indicates that the 1965 enactment of the Good Samaritan Law covers any emergency or accident. The enclosed copy of this act provides for exemption from civil liability for "emergency care without fee at the scene of a motor vehicle accident or in case of nuclear attack. . . ."

Since the incidence of bringing civil liability into the picture where a physician in good faith renders care at a roadside accident appears to be more of a myth than a reality, it would seem that national concern for these enactments may represent something of an over-reaction.

Sincerely,

Donald J. Caseley, M.D.

Vice Chancellor at the Medical Center

### **§ 2a. Emergency care of injured persons—Exemption from civil liability**

Any person licensed pursuant to this Act or any person licensed to practice the treatment of human ailments in any other state or territory of the United States, except a person licensed to practice midwifery, who in good faith provides emergency care without fee at the scene of a motor vehicle accident or in case of nuclear attack shall not, as a result of his acts or omissions, except willful or wanton misconduct on the part of such person, in providing such care, be liable for civil damages. 1923, June 30, Laws 1923, p. 432, § 2a, added 1965, June 21, Laws 1965, p. 995, § 1.

Library references: Physicians and Surgeons Key 7, 18 (1/4); C.J.S. Physicians and Surgeons §§ 55, 60; I.L.P. Medicine and Surgery § 31.

## *St. Clair County Medical Society says thanks*

November 25, 1970

The dedication and professionalism of the men who are the leaders in the Illinois State Medical Society, as illustrated at the October 24, 1970, meeting of the Board in Belleville, merit the thanks and appreciation of the members of the St. Clair County Medical Society.

I, personally, and in compliance with specific instructions from the members of the St. Clair County Medical Society, extend gratification not only for assembling within this Society's jurisdictional area, but for the thoroughness demonstrated in your efforts to further the community

health of the State of Illinois, and the welfare of the individual physicians who practice in the state.

The ISMS' program to bring at least one of its monthly meetings into the "field" is a splendid idea.

My hat is off to Dr. Willard Scrivner, your chairman, all members of the Board, and ISMS' able staff.

Sincerely,

Stuart W. Mauch, M.D.  
President



IMJ  
*Illinois Medical Journal*

# Tubal pregnancy in a patient with an IUD

BY VINCENT S. DiGIULIO, M.D., F.A.C.O.G., F.A.C.S./JOLIET

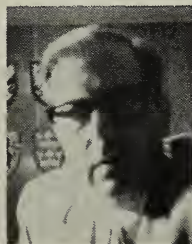
## Case Report

The diagnosis of tubal pregnancy depends primarily on a high index of suspicion by the attending physician. The wide spread use of contraception today may dull this index of suspicion. Therefore the occurrence of tubal pregnancy in a patient with an IUD warrants attention to alert physicians to this "red herring."<sup>1</sup> In the following case the classic triad of tubal pregnancy was present and the patient had an IUD for one year.

Mrs. X., Silver Cross Hospital patient, 24-years-old, para 1, Gravida 2 presented on May 7, 1969 with complaint of a heavy menses on May 3, 1969 and intermenstrual spotting. The IUD was placed on February 26, 1968 uneventfully. She relates that on April 12, 1969 she had a scant menses and that her previous menses was on March 15, 1969. She reported pain in the right lower quadrant. Re-examination two days later revealed a heavy "menstrual flow." She also noted pain on the lateral side of the neck and dizziness. No signs of collapse were noted and rebound was noted

in the right lower quadrant. The patient had a normal full term pregnancy in 1966. The past history was normal.

On May 14, 1969 the patient was admitted to the hospital and on May 15, 1969 a D & C and exploratory laparotomy were performed. At laparotomy there was 150-200 cc of old blood in the cul-de-sac. The right tube was adherent to the right ovary and tip of the appendix with an old clot. An opening was noted in the distal one-third of the tube. The right tube was resected. The pathology reports typical changes of tubal pregnancy. The patient had an uneventful recovery.



Vincent S. DiGiulio, M.D., F.A.C.S., is a Joliet obstetrician and gynecologist. A graduate of the University of Illinois, College of Medicine, he is an assistant clinical professor of OB-GYN at the University of Illinois, College of Medicine. Dr. DiGiulio is a Fellow, American College of OB-GYN and Diplomate, American Board of OB-GYN.



## Discussion

Chen and Ta-Ko report 6 cases of ectopic pregnancy associated with the Lippes Loop. Other problems involved were lost device, bowel obstruction, perforation of the uterus and failure rates of 2.5 per 100 woman years. Wilson reports 3 tubal pregnancies in 623 women. Vargo reports a pregnancy in a bicaurnate uterus with the use of a Lippes Loop. Hall reports two cases of small bowel obstruction from IUD or a rate of 1.936. He relates that Tietze reports a rate of 1:2,392, and 1:400 by Ledger and Wilson. Corfam and others report induction of uterine epidermoid carcinoma by plastic and stainless steel intra-uterine devices.

The value of the IUD however, cannot be denied. The device has a use in:

1. The patient who has thrombo-embolic potential in whom progestational contraception is contra-indicated.
2. The patient who cannot undergo surgical sterilization or tolerate the pill for emotional or physical sequelae.
3. The patient who finds the diaphragm method unsatisfactory.
4. The patient who is ambivalent about contraception or the patient who will

not be upset if pregnancy occurs.

It is suggested that a consent form be signed for all patients receiving IUDs:

"I, ....., consent to the insertion of an IUD. I understand that no guarantee against pregnancy is assured. I understand that the device may wander out of the womb and surgery may be required for its removal."

Witness:.....

## References

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9. Wilson, J. R., Ledger, W. J., Bollinger, C. C., and Andros, J. J., *Amer. J. Obstet. and Gyn.*, 92:62, 1965.



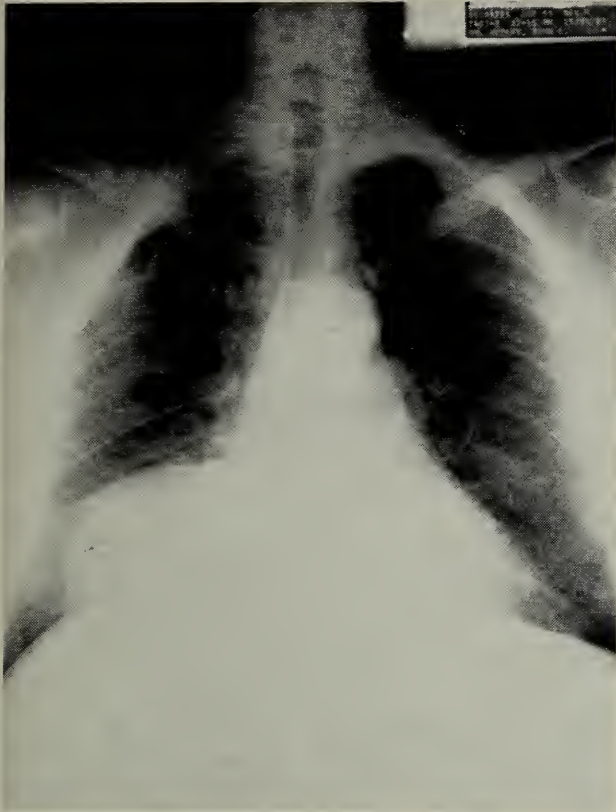
## the view box

A 51-year-old male came in with a complaint of pain in the right upper quadrant of his abdomen for a period of two months. The pain was constant in duration. He had also noted an increasing shortness of breath over the last several years. He had several traumatic episodes—the latest of which occurred in 1966, when he was hit by an automobile, suffering a fractured pelvis requiring hospitalization for six weeks. His

physical examination upon admission disclosed some dullness to percussion in the lower part of his right chest anteriorly. Otherwise there were no significant findings. What's your diagnosis?

1. Carcinoma of the right lower lobe with atelectasis
2. Encapsulated effusion
3. Traumatic herniation of the right hemidiaphragm
4. Pericardial cyst

# the view box



**Figure 1**



**Figure 2**



**Figure 3**

(Answers on page 200)





## surgical grand rounds

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial, and the Veterans Administration Research Hospitals form the usual basis of the discussions. This case report was part of the Surgical Grand Rounds of May 2, 1970.*

# Hydronephrosis

EDITED BY JOHN M. BEAL, M.D.

### Case Report:

**Dr. Bernard Johnson:** A 72-year-old woman was awakened with sharp, cramping mid-abdominal pain approximately six hours before admission. The pain was constant, gradually becoming localized in her left side. She became nauseated, started to sweat and vomited a small amount of greenish material. She had one small bowel movement of normal color. The pain was so severe that she was not comfortable in any position. Her urine was clear in color. She did not have symptoms of dysuria or urgency. She was seen by a physician who made a diagnosis of renal colic and sent her to the hospital. Three years prior to this admission, she had a similar episode of left flank pain which was constant in nature. She was thought to have a urinary tract infection. An intravenous pyelogram showed a questionable filling defect in the left renal hilum. Six months before the present admission, she had another episode of left back pain. At that time, evidence of a urinary tract infection was lacking and a urogram appeared to be normal.



Fig. 1. Intravenous pyelogram demonstrates left hydronephrosis, indicating an obstruction at the ureteropelvic junction.

Physical examination at the time of admission: temperature, 97.4°F.; pulse 68; blood pressure 132/70; respirations 20. Significant physical findings were a systolic ejection murmur over the lower left sternal border. Examination of the abdomen revealed active bowel sounds without tenderness, rigidity or masses. Good pulses were felt in both femoral arteries.

Laboratory studies: hemoglobin 12.7 gm.; hematocrit 38%; white count 5,600; BUN 25 mgm.% creatinine 1.7; serum electrolytes were normal. Urinalysis showed rare white and red blood cells, and was negative for protein, glucose or occult blood. A plain film of the abdomen was considered to be unremarkable. An intravenous pyelogram was performed.

**Dr. Abram Cannon:** The initial excretory study shows the kidneys fairly well. It appears the left kidney is larger than the right. The right kidney and calyceal group appear normal. On the left side, there is considerable irregular dilatation of the calyces and the kidney pelvis is full. (Fig. 1) These findings indicate an obstruction at the ureteropelvic junction. A subsequent urogram was done three days later. Again, there is rather marked dilatation of the calyces and kidney pelvis on the left. The left ureter is not seen. On both of these studies there was delayed excretion on the left side.

**Dr. Johnson:** Approximately eight hours after the intravenous pyelogram, she developed severe left flank pain and a temperature elevation of 101°. A catheterized urine specimen showed many bacteria. After blood cultures were taken (which were later negative) antibiotic therapy was initiated. *E. coli* was cultured from the urine in a small colony count. When her temperature returned to the normal range, retrograde pyelography was obtained.

**Dr. Cannon:** The catheter was placed up in the region of the left kidney pelvis and retrograde injection of contrast material was performed. Again, there is marked, irregular dilatation of the calyces, with some filling of the kidney pelvis. On the ureterogram, the left ureter is of normal caliber up to the level of the kidney pelvis. (Fig. 2) Some of the contrast material enters the irregularly dilated calyceal system and pelvis. This indicates that the obstruction is at the ureteropelvic junction.

**Dr. Johnson:** The ureteral catheter was left in place as well as a Foley so that separate collections of kidney and bladder urine could be obtained. The temperature remained normal and the pain was less severe. When the ureteral



Fig. 2. Left retrograde pyelogram shows normal ureter with a dilated calyceal system and renal pelvis.

catheter was removed, the pain recurred and she developed exquisite tenderness on palpation of the left flank. It was apparent that surgical correction of the obstruction of the ureteropelvic junction was required.

She was operated upon through a left flank incision and was found to have a large parapelvic cyst at the renal hilum which was compressing the ureter. This was drained and the edges oversewn.

**Dr. Joseph Sherrick:** We received a number of portions of tissue from the cyst and the peripelvic fat. In the adipose tissue there was considerable organizing acute and chronic inflammation. There were also areas of fairly dense fibrosis. A section of the cyst wall showed that it was lined by flattened cells, probably fibroblasts or endothelial cells. (Fig. 3) The wall of the cyst was composed of fibrous connective tissue. Lymphatics were not very abundant, but we did see some empty spaces which we believe are dilated lymphatics.

Cysts near the renal pelvis are rare. One should consider diverticulum of the renal pelvis, which can be identified by the transitional epithelial lining, not present here. Cystic hematomas may occur in the pararenal region, but there is no evidence of blood staining in this specimen. Cystic tumor, dermoid cyst and echino-



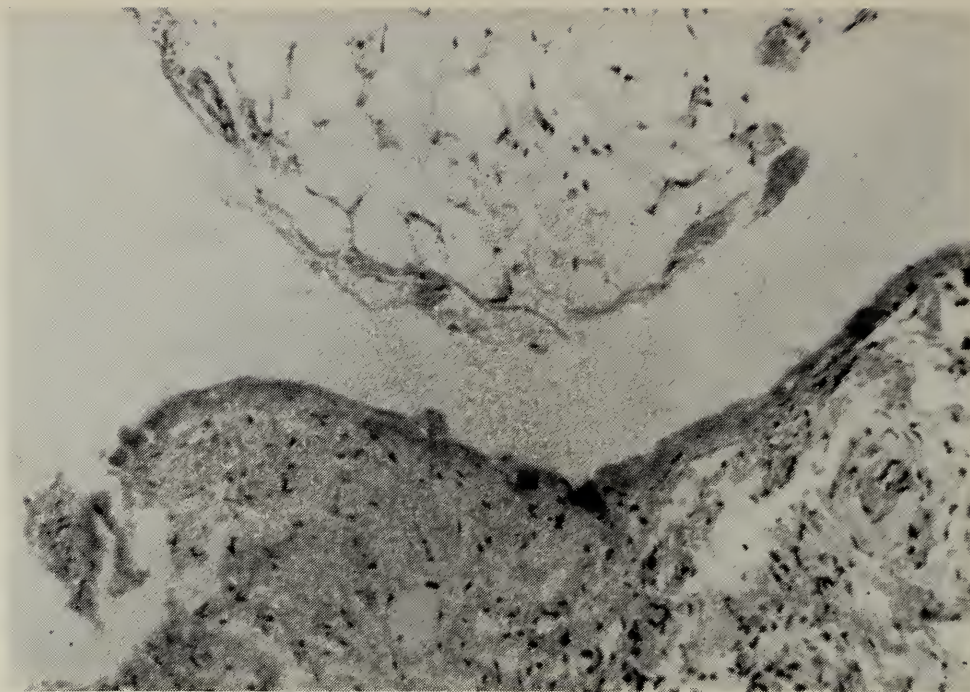


Fig. 3. Wall of parapelvic cyst showing lining of flattened cells.

coccus cyst can readily be eliminated by a lack of characteristic histopathologic findings. Cysts of the type present in the case under discussion have been studied by Henthorne, who believes that they are lymphatic cysts. This is supported by the finding of dilated lymphatics near the cyst. These cysts are not very common, although an incidence of as high as one per cent in a series of autopsies has been reported. I don't think we have seen that many but we probably missed them because we haven't looked for them. Most of them are incidental findings, but they may produce filling defects of the pyelogram, and few have caused obstruction and hydronephrosis.

**Dr. Kenneth Kropp:** This patient had obvious obstruction of the left kidney with infection manifested by the daily spiking fever. However, the cause of the obstruction was obscure and did not seem to be caused by a calculus. The X-rays taken during the past three years were reviewed, but only added to the uncertainty of the diagnosis. Although a filling defect was suspected in one study, subsequent pyelograms failed to confirm its presence. The pyelograms at this time merely indicated obstruction of the left renal pelvis with dilatation of the calyces. When the retrograde pyelogram was performed, the catheter went easily into the pelvis of the left kidney. This relieved the obstruction and copious urinary drainage followed. Her fever came down. The catheter was left in place for about five days. Although she really had very little pain

and was afebrile, after the catheter was taken out, we repeated the intravenous pyelogram.

**Dr. Cannon:** Poor visualization was obtained, but some contrast material shows dilated calyces, indicating obstruction is still present.

**Dr. Kropp:** On the basis of persistent obstruction of this kidney, we explored the left kidney with a differential diagnosis of ureteropelvic junction obstruction caused by stone, parapelvic cyst, xanthogranulomatous fat formation or tumor. With these diagnoses in mind, we had evaluated her other kidney to make sure it was capable of sustaining life if nephrectomy was required. The ureter was dissected into the renal hilum. During identification of the ureteropelvic junction, which was partially intrarenal, we ruptured the parapelvic cyst, which was surrounded by fat and was about 4 to 5 mm. in thickness. Once the cyst was ruptured, unroofed and biopsied, the renal pelvis was decompressed. We did not open the urinary tract.

In addition to the comments referable to parapelvic cyst, I'd like to say something about hydronephrosis. The kidney is unique in its reaction to obstruction. If you obstruct the duct of a secretory organ, like a salivary gland, the gland atrophies. The kidney responds differently. The kidney continues to make and secrete urine, in spite of a high degree of obstruction. Hydro-nephrosis is the result.

Urine formation is the product of glomerular filtration plus tubular secretion and reabsorption. If the kidney is obstructed, the pressure in the



pelvis, which is then transmitted to the renal tubule, becomes greater than the filtration pressure. When the pressure rises sufficiently, filtration ceases. In an acutely obstructed kidney, pressures of 80 or 100 mmHg. may be generated in the renal pelvis.

There are probably other channels or pathways that urine takes to get out of the kidney. These include backflow from the renal pelvis into the blood stream, so-called pyelovenous backflow, backflow into lymphatics, actual rupture of the kidney pelvis near the fornix or the calyx, and extravasation of contrast media outside of the kidney into the sinus renalis and then out into the parapelvic tissues.

The pyelolymphatic backflow, pyelovenous backflow and actual peripelvic extravasation are the means that restore or lower the intrarenal pressure. When filtration pressure is restored, the kidney begins to make urine again.

There is evidence that these communications actually exist. If the kidney is obstructed acutely and PSP dye is placed in the pelvis of the kidney, after several days the PSP will be gone and will be excreted by the other kidney. Although this may be related to diffusion out of the kidney pelvis, it is more likely related to communication between the pelvis and the venous system.

Other experiments have been performed to demonstrate the egress of fluids from the kidney pelvis. A catheter was placed in an obstructed kidney pelvis and radioactive hippuran was introduced into the renal pelvis in increasing amounts. After approximately 30 minutes, as the intrarenal pressure rose, radioactivity was detected in the femoral vein blood. When the pressure reached a slightly higher level, radioactive material began to escape from the renal pelvis. In spite of continued infusion of the radioactive material, the intrarenal pressure fell and then the radioactivity in the peripheral blood began to rise.

In another experiment, colloidal gold has been injected into an obstructed renal pelvis. Colloidal gold is not picked up by lymphatics, so it is removed from the kidney by actual communication of renal pelvis with the blood. Indeed, colloidal gold has been found to escape from the renal pelvis into the peripheral blood in the presence of obstruction.

There are functional changes that occur with hydronephrosis, such as the inability of the kidney to acidify or to concentrate urine. A decrease in glomerular filtration rate and renal plasma flow can be determined in an obstructed kidney.

For some time, it was generally accepted that the renal plasma flow and renal blood flow fell as soon as obstruction took place. However, this has been shown not to be the case. After an acute obstruction of the kidney, if diuresis is induced, the renal blood flow may actually increase. However, if you measure PAH extraction, the extraction is less. Thus, it appears that, although initially renal blood flow increases, the cortex of the kidney is probably not being perfused.

**Dr. Thomas Shields:** How often does this rupture of the fornix into the sinus renalis occur? Isn't that a relatively rare mechanism of decompression of the pelvis?

**Dr. Kropp:** It has been estimated that from 5 to 10% of patients with renal obstruction will show this phenomenon. We have seen it two or three times in the last six months.

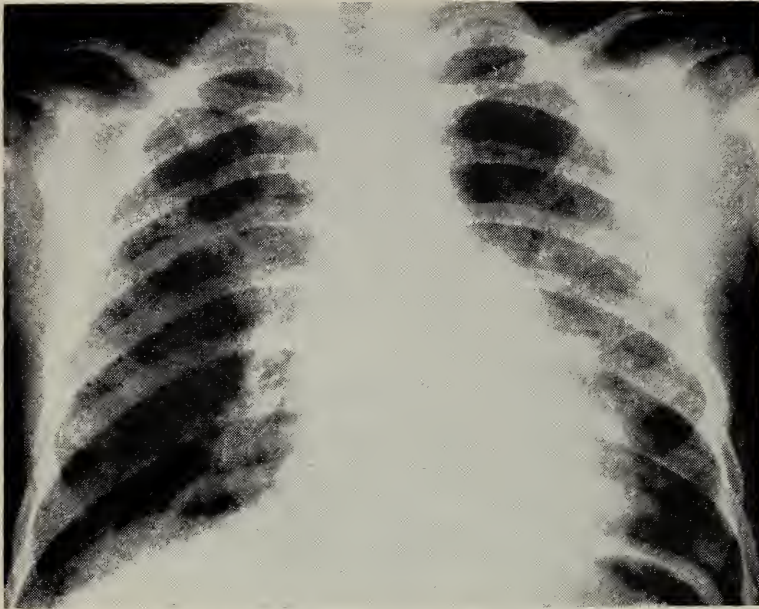
**Dr. Shields:** What happens if you don't do any operative intervention? Will this clear spontaneously or is this manifested in a more serious clinical course for the patient?

**Dr. Kropp:** Probably, especially if the urine is not infected and the obstruction is relieved or if a stone is passed spontaneously, this will not cause a problem. Of course, if the urine is infected or if there is persistent obstruction, operative intervention might be required.

**Dr. Leander Riba:** I saw this patient preoperatively and was also in the operating room when Dr. Kropp operated. An interesting sidelight is that a short time ago, W. W. Scott from Baltimore pointed out in correspondence, the anomalies and pathologic lesions which run in families. His particular reference was pheochromocytoma in a rather extensive family. I happen to have taken care of this patient's son when he was a teenager. He had an obstructed kidney on the left side which was badly infected, long before we had any antibiotics. His right kidney was small and atrophic, and he also had bilateral undescended testes. His obstructed kidney was opened and we performed a pyeloplasty. He has remained well.

Just a word about parapelvic cysts. Ormand Culp from Rochester recently wrote an extensive article on parapelvic cysts. He pointed out the difficulties in making a diagnosis that were mentioned by Dr. Sherrick, as well as the difficulties in managing these cases at the time of operation. Poor postoperative results are occasionally obtained. In this case, Dr. Kropp did a very careful dissection and I think he marsupialized the cyst so well that she should obtain a very satisfactory result.



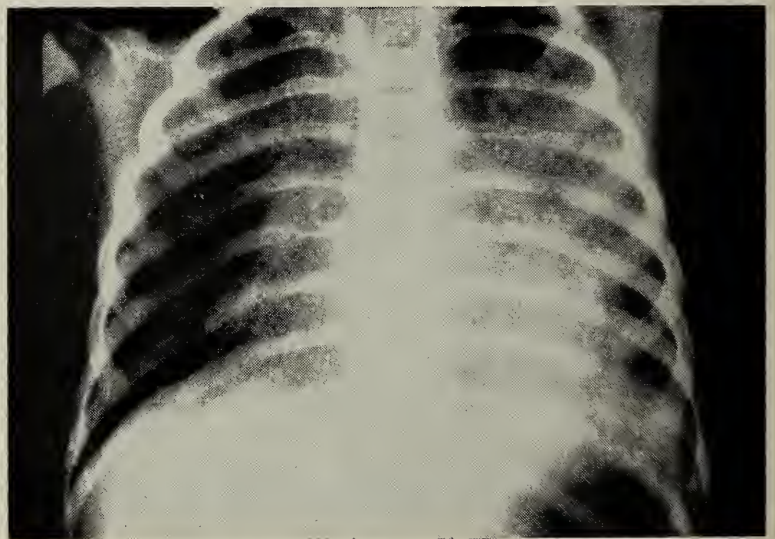


*Fig. 1.* Chest roentgenogram reveals a bilateral perihilar infiltrate. There is no evidence of fluid or other abnormality.

# Hypertension and duodenal ulcer

## Associated with pneumocystis carinii pneumonitis and dysgamma-globulinemia

BY ENRICO T. FARINAS, M.D., AND JORGE A. QUEL, M.D./CHICAGO



*Fig. 2.* (12 days later) Diffuse haziness and patchy infiltrations are present, which appears to be extended outward from both hilar areas. The findings are much more pronounced than Fig. 1. Impression: Bilateral interstitial pneumonia.

*Pneumocystis carinii* pneumonitis has been reported in association with several clinical entities, including dysgammaglobulinemia. However, nowhere could we find a report of this unusual form of pneumonitis and dysgammaglobulinemia occurring in association with hypertension and duodenal ulcer.

## Case Report

L. R., an 11-month-old female, was admitted because of cough, fever, lethargy, shortness of breath, intermittent choking and cyanotic spells of four days duration. She was born spontaneously, weighing 5 pounds, 6 ounces. There were no postnatal problems. At the age of 40 days, she started having upper respiratory infections. She received three injections of DPT and 2 OPV's. No Shick Test was done. TB test (1:1000) was negative. Her growth and developmental pattern were normal. A paternal cousin had a history suggestive of immunoglobulin deficiency. Her parents were both from Colombia, South America.

**Physical findings:** Examination revealed a fairly well developed and nourished, dyspneic child with intermittent episodes of coughing. Temperature—100°F; weight—17 pounds, 13 ounces; respiratory rate—30-40/minute; blood pressure—110/60; pulse rate—120 per minute. Lower intercostal retractions were noted with flaring of the alae nasi. The lungs revealed inspiratory rales at both bases posteriorly. The remainder of the examination was normal.

**Laboratory examinations:** Urinalysis, CBC, sweat chloride test, cold agglutinins, blood cultures, serum electrolytes, CSF examination, E.K.G. and echoencephalogram were unremarkable. Complement C<sub>3</sub> — 270 mg.%. Throat culture showed *E. coli*. Initial chest roentgenogram was essentially normal. Immunoglobulin quantitation was performed. (Tables I & II)

**Table I**  
**Immunoglobulin quantitation:**

	Patient	Normal for age group
IgG	Less than 50 Mgs.%	320-1250 Av. 630
IgA	Less than 30 Mgs.%	17-19 Av. 40
IgM	60 Mgs.%	30-216 Av. 80

**Table II**  
**Quantitation by more Sensitive Methods:**

	Blood	Saliva
IgG	Approx. 30 Mgs.%	0 Mgs.%
IgA	Approx. 20 Mgs.%	0 Mgs.%

**Course:** The cough, dyspnea and cyanosis progressed in spite of oxygen administration. The respiratory rate ranged from 100-110 per minute. The liver, originally not felt, became palpable 2 cms. below the right costal margin. The blood pressure was noted to be elevated, ranging from 170/70 to 230/80. Initial treatment consisted of antibiotics (Ampicillin), IV fluids, digitalis and a hypotensive drug (Reserpine). Gammaglobulin was also given. Because of the progression of the respiratory distress which was not proportional to the auscultatory findings, the presence of pneumocystis carinii pneumonitis was entertained. Repeated chest roentgenogram showed bilateral interstitial pneumonia. (Figs. 1 & 2) Despite the absence of the organism from the tracheal secretions using silver stain, the patient was placed on Sulfadiazine-Daraprim combination. She was also treated with diuretics, staphicillin, kanamycin and sedatives. There was no improvement after two days of sulfa-pyrimethamine combination. The patient had episodes of convulsions, emesis, and dark liquid stools which were positive for occult blood. She was placed on a Bennett respirator with improvement of the cyanosis. Serial serum electrolytes, pH and CO<sub>2</sub> determinations were normal. However, she expired on the ninth hospital day.

**Postmortem findings:** Necropsy examination of the liver, heart and blood vessels, thymus, pancreas, brain, adrenals and the kidneys was unremarkable. Numerous sections taken from various lymphnodes show nearly complete absence of germinal centers.

There was an oval punched out ulcer in the posterior wall of the duodenum 1 cm. distal to the pyloric ring. It measured 5x10 mm. and was 0.3 mm. in depth. (Fig. 3)

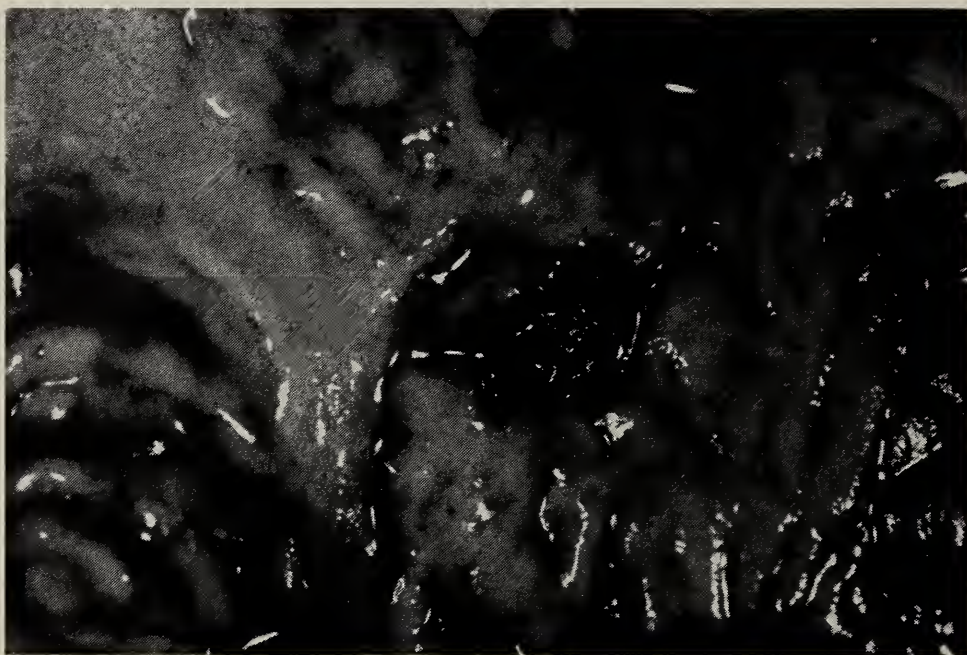
On palpation all lobes of the lung felt markedly firm and noncrepitant. Serial sec-

*From the Department of Pediatrics, Illinois Masonic Medical Center, Chicago.*



tioning revealed lung tissue showing a uniformly mottled appearance with pink-tan areas alternating with somewhat lighter staining gray areas. Figure 4 shows the classical appearance of the pneumocystis carinii organisms.

degree of respiratory symptoms.<sup>1,2</sup> The patient may either die within a few days after symptoms have developed or recover slowly during a period of two to three weeks to several months. The overall duration of the illness is from four to six weeks with an in-



**Fig. 3. Duodenal ulcer, posterior wall.**

The mucosal surfaces of the intestinal tract were normal. Peyer's plaques were noted in diffuse, lymphocytic aggregates, but germinal centers were conspicuously absent. Careful examination of the lamina propria for plasma cells showed absence of these cells.

### **Diagnostic features**

There are no pathognomonic clinical features of this unusual form of protozoan pneumonitis. The onset is usually insidious with tachypnea and circumoral cyanosis as the first respiratory signs. Initially there are no auscultatory findings in the chest; fever and cough are not prominent. The respiratory rate continues to increase, followed by severe cyanosis, dyspnea, marked intercostal retractions and nonproductive cough. During the height of distress, fine crepitant rales may be heard but not proportional to the

incubation period of about six weeks.

The suggestive chest X-ray finding is perihilar haziness which spreads peripherally and subsequently develops into a generalized granular pulmonary parenchymal pattern. This may progress to coalescing nodules and finally to peripheral absence of aeration. The absence of hilar lymphadenopathy or pleural effusion is striking.<sup>3,4</sup> Areas of compensatory emphysema may be seen. When the disease is strongly suspected from the clinical and roentgenographic findings, the diagnosis may be confirmed by tracheal aspiration or percutaneous pulmonary needle biopsy with appropriate staining.<sup>5</sup>

A complement fixation test employing an antigen prepared from infected subjects is specific for the disease and was reported to be reliable in more than 90% of the cases.<sup>6</sup> However, this has not yet been employed to any extent in this country.

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## Treatment

To date, the most effective treatment is pentamidine isethionate in dosage of 4 mg. per kilogram per day for 10-14 days. It is a diamidine compound. Its pharmacologic action is either as a folic acid antagonist or as an inhibitor of aerobic glycolysis of the organism. The side effects are hypotension when given intravenously and folic acid deficiency.<sup>7</sup> This drug is available for clinical investigation from the Parasitic Disease Drug Service of the National Communicable Disease Center, Atlanta, Georgia.

Hydroxystilbamidine therapy has similar characteristics and side effects, and is more unstable and causes trigeminal neuropathy.

A combination of sulfadiazine and pyrimethamine (Daraprim) may prove to be a useful alternative to pentamidine and should be given for 14-21 days. Sulfadiazine is given 100 mgs. per kilogram per day. This combination is used to prevent the development of resistance to Daraprim.

The use of pyrimethamine and sulfa combination was used in our case. This drug combination was described by Rifkind and Associates in the treatment of pneumocystis carinii infestation in two adults with suggestive evidence of improvement.<sup>8</sup> However, their patients subsequently died. There was no improvement observed in our patient, raising doubt as to the value of this combination.

## Discussion

Pneumocystis carinii is an opportunistic organism. It usually occurs in patients with debilitating disease and in those with disturbed immune mechanism either primary as in congenital immune deficiency states or induced by therapeutic agents.

Le Clair in his review of cases reported in this country, stated that the largest number occurs in infants less than one year of age. Of those reviewed, Illinois reported the greatest number of cases.<sup>9</sup>

Pneumocystis grows within the alveoli of the lungs. It has not been grown in vitro. It is considered to be protozoan; its morphology was first described by Chagas in 1909. When properly stained, it appears as spherical cysts about 4.5 u in diameter. Other forms are slightly wrinkled, cup-shaped and crescent-shaped.<sup>10</sup> The significance of contact or environmental transfer is still open to question. Pavlica believes that *P. carinii* is a latent parasitic infestation among human beings.<sup>11</sup> It has been described in association with Wiskott Aldrich Syndrome,<sup>12</sup> in a full-term macerated fetus, in a two-day old infant with Down's Syndrome,<sup>13</sup> in a ten-day old infant with diffuse pneumonitis,<sup>14</sup> in Letterer's-Siwe's Disease, in an entire family,<sup>15</sup> and in otherwise normal individuals.<sup>16,17</sup>

Pneumocystis carinii is a slow growing organism which affects the lungs by the for-

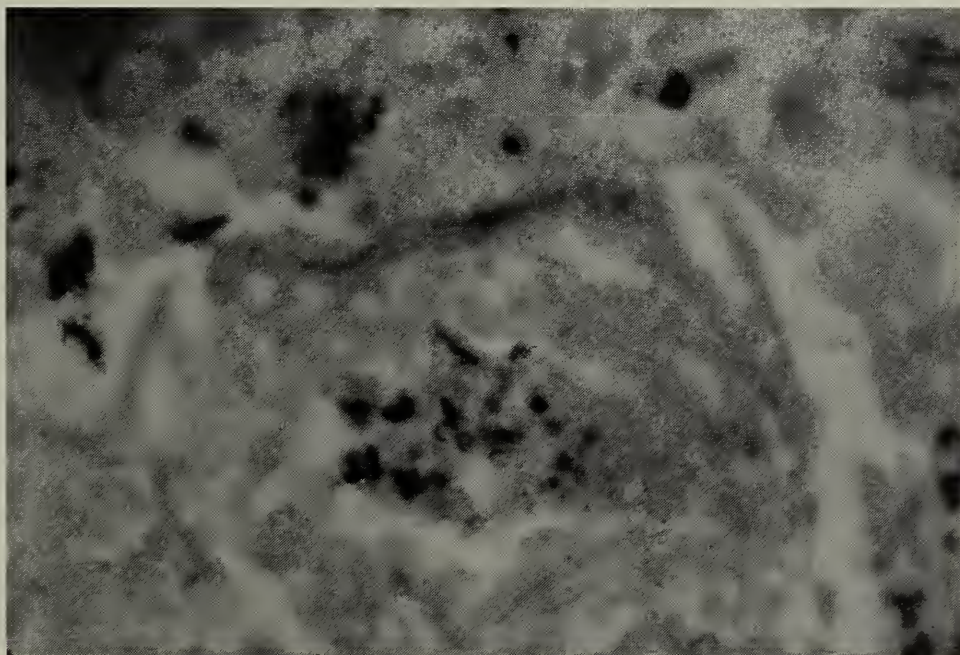


Fig. 4. Classical appearance of pneumocystis carinii organisms (Gomori's methenamine—silver stain).



mation of a predominantly intra-alveolar exudate provoked by the parasites. Consolidation and fibrosis are probably secondary reactions to the intra-alveolar exudate.

Mononuclear histiocytes and plasma cells are the most frequent inflammatory cells observed, but this reaction changes with the underlying condition of the host as in pre-matures and older children with disturbed immune mechanisms.

The nutritional and biochemical environment of the alveolar space necessary to produce growth of the parasite has not been duplicated in vitro; probably the high antibody content of the pooled sera of the culture media may interfere.

Our patient has a marked decrease of the IgG with normal IgA and IgM levels.

The selective deficiency of one or two immunoglobulins, usually designated as a dysgammaglobulinemia, has received different forms of classification during recent years. According to Dr. Johannes Huber, this particular deficiency state would come under Group 3. However, Rosen and Jane-way's Group is an isolated absence of IgA.<sup>18</sup>

The disparity in grouping and numbering was discussed at a recent World Health Organization Conference and the need for a flexible classification was emphasized. Drs. Selegman of Paris; Faundenberg of San Francisco; and Good of Minneapolis, placed the dysgammaglobulinemias in a primary immunoglobulin aberrations group. This group includes the nonsex-linked primary immunoglobulin deficiency with variable onset and expression.

In our present case, the integrity of the thymus-dependent-system (cellular immunity) and a clear deficiency of the bursa-dependent-system (humoral immunity) can be based on these observations:

1. A grossly and microscopically normal thymus.
2. The nearly complete absence of the germinal centers in the lymphatic tissue and the normal lymphocytic population in the paracortical areas (thymic-dependent).
3. The absence of follicular structure in the very poorly developed Peyer's patches.
4. The total absence of plasma cells in the patient's lamina propria.

An unusual association in this case was

a large, deep excavated ulcer, oval in shape, measuring 5 x 10 mm. and 0.3 mm. in depth, located in the posterior wall of the duodenum. Histologically, there was acute and sub-acute reaction surrounded by fibrotic tissue. This reaction indicated a possible chronic condition of several weeks duration. Therefore, the possibility of a stress situation is unlikely. Examination of the ulcer for pneumocystis carinii, cytomegalic inclusion bodies and fungi was negative. The brain was normal, ruling out a Rokitansky-Cushing ulcer.

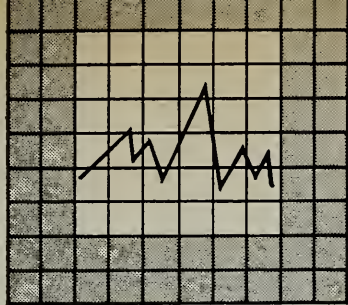
Another interesting finding which developed during the hospital stay was the elevated blood pressure ranging from 170/70 to 230/80. Related laboratory data were normal. The autopsy report revealed normal suprarenals, kidneys and brain; thus, no cause could be demonstrated for the hypertension. ◀

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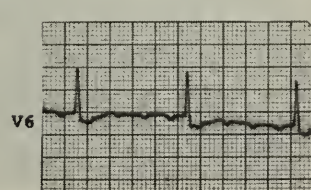
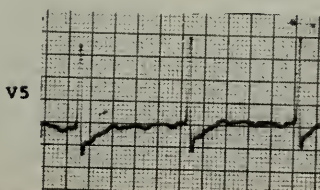
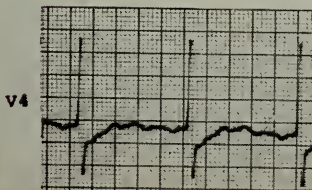
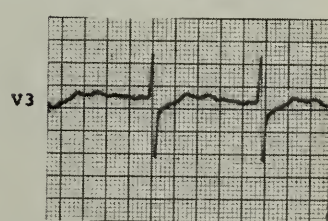
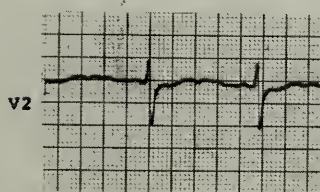
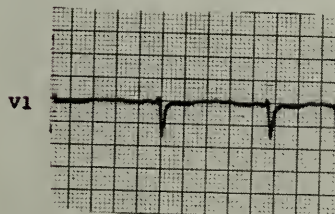
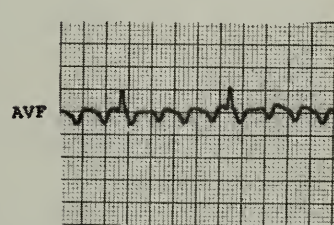
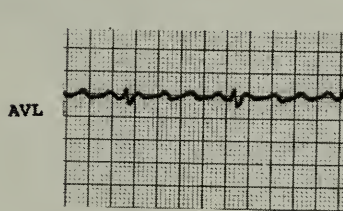
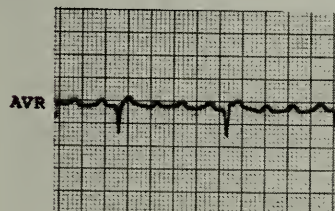
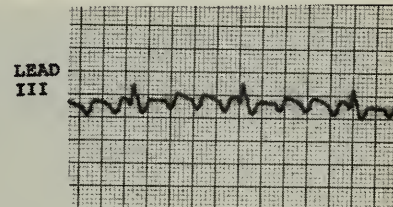
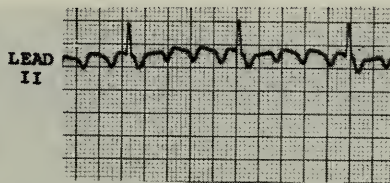
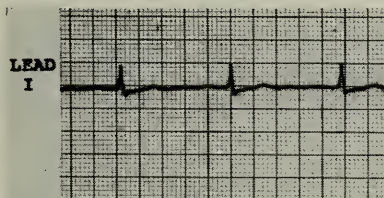
JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS,  
M.D. AND PATRICK SCANLON, M.D./SECTION OF CARDIOLOGY,  
DEPARTMENT OF MEDICINE  
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A 73-year-old white male was admitted with a history of Lt. hemiparesis of 4 hours duration. A system review disclosed complaints of oppressive substernal pain with exertion of three years duration and periodic episodes of palpitation and dyspnea of three months duration. Physical examination disclosed a radial pulse rate of 75. With the patient reclining at 45°, the neck veins were distended and oscillations were present. No precordial thrills or lifts were palpated. The Lt. heart border was in the 5th interspace and the mid-clavicular line. S<sub>1</sub> was slightly diminished in intensity at the PMI and S<sub>2</sub> was slightly accentuated at the 3rd Lt. and the sternal border. The aortic and pulmonic components were closely split. Auscultation revealed atrial sounds.

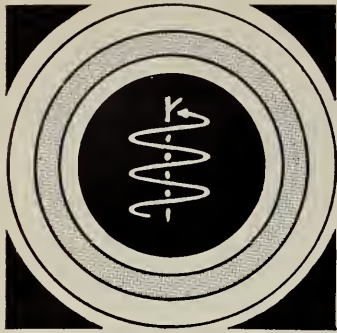
**Questions:** (One or more of the choices presented may be correct.)

1. The electrocardiogram showed:
  - A. Atrial fibrillation with junctional rhythm.
  - B. The atrial and ventricular rates are the same.
  - C. Atrial flutter with 4:1 A-V block is seen.
  - D. LBBB is present.
  - E. Atrial rate is 260/min.
2. Probable clinical conclusions are:
  - A. Cerebral hemorrhage caused hemiparesis.
  - B. Ischemic heart disease with angina pectoris is present.
  - C. Cerebral embolus caused hemiparesis.
  - D. The presence of 4:1 Atrio-Ventricular Block without previous cardiac drug therapy makes anti-arrhythmic treatment hazardous.
  - E. Cardioversion should be attempted.

(Answer on page 168)







## medical progress

BY E. RICHARD BLONSKY, M.D./CHICAGO

The neurological syndrome manifested by tremor, rigidity and akinesia has been known since ancient times. Galen probably described a victim of this disease in his essay, *De Tremore*. Over the years this affliction became known as *paralysis agitans* and in 1817, James Parkinson, a British physician, wrote his famous *Essay on the Shaking Palsy*.<sup>1</sup> He delineated the clinical manifestations to an exquisite degree and no subsequent descriptions have surpassed his. For the past century and a half this disorder has been known simply as Parkinson's disease, and more recently as parkinsonism, that one lower case word denoting the diverse manifestations of the syndrome which at times resembles the classical picture although resulting from other than classical causes.

# The role of L-DOPA in the of patients with

### Physical description

A brief description of the symptoms should suffice to reacquaint the reader with the disease, and will act as a springboard for further discussion. Tremor is the symptom which usually brings the patient to the physician. Usually occurring at rest and pill-rolling in appearance at the outset, it does not interfere with performance of tasks at work or about the house. Later, the tremor may be seen on static extension causing great problems to the housewife slicing vegetables or the man attempting to tighten a screw. Rigidity is a state of heightened tone of somatic muscles involving both agonists and antagonists so that resistance to passive movement is felt through the full range of movement about a

joint. This state of rigidity also affects the muscles of the trunk with resulting postural disturbances. There is a characteristic "tortoise" appearance as the neck and head are thrust forward. The body is flexed at the waist and a dorsal kyphosis develops in the upper spine; the knees tend to be flexed. Facial muscles become rigid with development of a mask-like expressionless facies and an unblinking reptilian stare. Associated movements tend to be lost such as the arm swing in walking, and handwriting becomes micrographic.

Akinesia refers to disturbance in movement and includes several features. There is a definite delay in initiation of movements, slowness in carrying them out, and frequent interruptions

or "freezing" during performance of movements. This "freezing," often seen while walking, is exaggerated as the patient approaches a doorway or narrow passageway. It frequently involves hand and arm movements and may even be noted in speech, with the patient aware that he loses his thoughts while speaking. Associated with the postural abnormalities is a disturbance of balance with a tendency toward propulsive or retropulsive movements. Since akinesia interferes with normal stabilizing and righting reflexes, falls frequently occur.

Gait is impaired and at times impossible. The advanced patient typically shuffles on his toes because of the postural disturbance; takes short, stuttering steps—*marche a petits pas*; and festinates as he runs in short bursts in an attempt to catch his feet up to the propelling trunk.

Other manifestations include softness of voice and dysarthric speech; sialorrhea, impaired swallowing and drooling; and autonomic dysfunction with seborrhea, "flushing," disturbed bladder and gut tone.

Over the years parkinsonism has been considered a progressive debilitating disease which inevitably leads to near total disability with con-

### Looking back

We have seen many patients in the younger age groups who have been retired early because of parkinsonism or were just "hanging on the ropes" as far as their jobs were concerned. Admittedly, over the years there has been little we could offer these people from the standpoint of truly effective treatment. The various drugs useful in parkinsonism—antihistamines, natural or synthetic anticholinergics, phenothiazine-related agents, etc., did offer some relief with slight control of tremor or transient easing of rigidity. Effectiveness of these drugs seemed to diminish with time, while the disease progressed and in no way could its inevitable ravages be arrested. For the clinician, the treatment of parkinsonism was a frustrating exercise as the inexorable progress distorted the physical being while the intellect was spared. It was heart-rending to see strong men reduced to levels of infantile dependency, aware of these changes in themselves and severely depressed because of them.

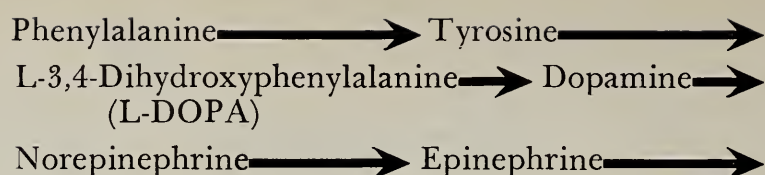
A revolution began in 1960, when Hornykiewicz<sup>2,3</sup> and co-workers noted a deficiency of dopamine, a catecholamine, in the basal ganglia of patients with parkinsonism. Almost simultan-

# functional rehabilitation Parkinson's Disease

current development of a state of increasing dependency on family or attendants for maintenance of even minimal levels of hygiene, nutrition, etc. Disability boards, acknowledging the long range prognosis for the parkinsonian, have been prompt to certify for total disability status. Private industry has been eager to divest itself of the person with parkinsonism for many reasons, both altruistic and blatantly selfish. It is obvious that the person with akinesia is in jeopardy if his duties include operation of rapidly moving machinery, punch presses, etc., but of even greater significance is the problem raised by decreased productivity, inability to communicate, as speech becomes dysarthric and voice inaudible, or write, since handwriting becomes micrographic because of tremor.

eously Barbeau<sup>4-6</sup> and his group in Montreal, determined that patients with parkinsonism excreted less dopamine and its degradation product, homovanillic acid, in the urine than did the normal person. Concluding that a deficiency of dopamine in some way was related to the symptoms of parkinsonism, both investigators<sup>7,8</sup> attempted to treat the parkinson patients with dopamine, but this substance did not cross the blood-brain barrier. They fell back to the precursor of dopamine (Fig. 1) a chemical known as 3,4-dihydroxyphenylalanine (DOPA), and investigational treatment of patients with both oral and intravenous preparations was attempted. The (D,L-) racemic mixture was used both because of cost and availability. Results were variable





**Fig. 1. Levodopa Metabolic Pathway**

in terms of degree of alteration of parkinsonian symptoms and in duration of the effects. Over the next few years various reports were either confirmatory, or denied<sup>9</sup> the earlier papers, and DOPA was considered an interesting laboratory tool of no great significance.

In 1967, Cotzias, Van Woert, and Schiffer<sup>10</sup> reported the results of treatment of 17 patients with parkinsonism with large oral doses of D,L-DOPA with significant changes seen in their clinical pictures in terms of reduced tremor, lessened rigidity, quickened movements, etc. Dr. Cotzias' motion pictures of some patients taken before treatment and while on the drug were little short of astounding. Also, by eliminating the dextro-form of DOPA, which also does not cross the blood-brain barrier, many side effects were eliminated and the total dose of drug required was halved. His follow-up study<sup>11</sup> in 1969, confirmed his earlier findings and noted the long term benefits of such treatment. It is for this work that Dr. Cotzias justifiably received the Lasker Award in medicine in 1969. By turning this laboratory curiosity into a clinical tool he offered new hope to the estimated million and a half parkinson patients in the United States, and encouraged development of several investigational programs into the efficacy and side-effects of this drug.

In the past six months, many articles<sup>12-15</sup> have appeared in the neurological literature as authors from various centers have presented their results of treatment of large and small groups of parkinsonians with levodopa. We are also participants in a cooperative study of the effectiveness and side-effects of levodopa in the treatment of parkinsonism sponsored by Eaton Laboratories. To date, this study has analyzed the results of treatment of 485 patients scattered among 14 centers across the country. The most significant finding in all the studies has been the similarity of results noted by all investigators. In general, the proportion of patients improved by a certain degree; the side-effects, the laboratory variations, etc., have shown few differences from one center to another. The methods of administration of the drug, evolved independently, have been very nearly identical. The uniformity of

agreement as to the profound efficacy of this drug is quite unique in the annals of neurological chemotherapy. L-DOPA has been likened to insulin inasmuch as its administration supplies a missing biochemical substance which is needed for maintenance of good health. In addition, it must be taken daily in order to maintain this balance. At this moment parkinsonism appears to be a metabolic deficiency state, although the exact locus of the breakdown in the metabolic pathway has yet to be elucidated.

### Methods

Our study has been carried out at the Parkinson Clinic of Northwestern University Medical School, at Chicago Wesley Memorial Hospital, and by members of the Northwestern University-McGaw Medical Center. The basic requirement for inclusion in the study has been the presence of Parkinson's disease. The only patients who have been excluded have been those with severe dementia or frank psychosis; very recent myocardial infarctions; or severe hypotensive disease. Age and severity of disease did not enter into the evaluation process. Both inpatients and outpatients have been treated with generally successful results. Over 500 patients are in treatment, their ages ranging from 36 to 81 years, and with twice as many male patients as female.

Treatment on an outpatient basis has been geared to the clinic population and to selected private office patients. The major criteria for inclusion in this group have been that the patient is sufficiently ambulatory to make the regular trips back and forth for evaluation and that there be someone at home to observe and assist him in case of any untoward effects. The outpatients are treated in a cautious and conservative fashion typically following a schedule as seen in Table 1. The dose is increased slowly on a weekly basis in total increments of 500 mg. per day until a total daily dose of 3.0 g/day is achieved. Patients are maintained at this level, if they are able to achieve it, for one to two months and then further increments are made in a similar fashion until the optimal therapeutic level is reached, usually an average of 4.0 to 6.0 g/day. Those patients who are unable to toler-

ate 3.0 grams per day, or who display an adequate response at a lower dose, are maintained at that dose indefinitely.

Table 1. Typical Outpatient Levodopa Treatment Schedule				
	Mealtime Dosage (in milligrams)			
	Breakfast	Lunch	Dinner	Bedtime Snack
Week 1	250	0	250	0
Week 2	250	250	250	250
Week 3	500	250	500	250
Week 4	500	500	500	500
Week 5	750	500	750	500
Week 6	750	750	750	750

Inpatients are treated in a slightly more rapid fashion since they are under constant observation by the medical, nursing and physical therapy staffs. The inpatient program is so designed to evaluate patients in a matter of two to three days, determine their suitability for treatment with levodopa, and if acceptable for the study, to bring them to a 3.0 g/day level in two weeks, at which time they can be discharged and followed as outpatients. A typical dosage schedule for inpatients is outlined in Table 2.

Table 2. Typical Inpatient Levodopa Treatment Schedule				
Days 1-3 Clinical & Laboratory Evaluation & Testing				
	Mealtime Dosage (in milligrams)			
	Breakfast	Lunch	Dinner	Bedtime Snack
Days 4-7	250	250	250	250
Days 8-11	250	500	250	500
Days 12-14	500	500	500	500

It should be noted that medication is always given at meal times with food since this seems to greatly decrease the incidence of nausea and vomiting which may occur. Blood pressures are

Table 3. Beneficial Effects of Levodopa Treatment	
Diminished rigidity; progressive reduction of abnormally heightened muscle tone	
Reduced amplitude of tremor; less frequent displays	
Increased speed and ease of movements; less "freezing"	
Restoration of normal facial mimetic expression	
Clearer speech; greater vocal volume; increased duration of vocalization	
Improved handwriting—Micrographia enlarges	
Tendency toward resumption of more erect posture	
Improved balance; return of postural righting reflexes	
Improved gait with lengthened stride, ability to stand flat (off toes), decreased propulsions and festination, return of armswing	
Sialorrhea is reduced, swallowing improved, drooling ceases	
Improved autonomic functions: diminished seborrhea and "flushing;" improved bowel and bladder motility and tone	
Improved mentation, diminished confusion, greater social awareness and interaction	
Improved performance of activities of daily living: better able to dress self; feed self; chew and swallow; perform hygiene activities; get in and out of chairs, bed, autos unaided; performance of occupational and household chores, etc.	

obtained one-half hour after each dose, and graphic charting is maintained for the duration of the patient's hospitalization. Any variations, especially hypotensive episodes, can be readily noted and dealt with accordingly, usually by simply putting the patient to bed for awhile.

Results

The results of treatment with levodopa are summarized in Table 3. This list deals with the disabling features which were noted in the introductory portion of this report. Obviously not all patients respond in all areas or to the same degree. Each patient is evaluated before treatment and periodically thereafter while receiving levodopa, using a rating schedule which incorporates clinical neurological features such as mental status, posture, bradykinesia, tremor, etc., in combination with the Northwestern University Disability Scale<sup>16</sup> which assesses performance in activities of daily living. This standardized rating schedule has been used by all the investiga-



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pated in the Medical Center Program in Neurology as a U. S. Public Health Service Fellow. Dr. Blonsky is presently on the Medical Advisory Board of the United Parkinson Foundation, and an investigator in the Eaton Laboratories Cooperative Study on the Efficacy and Side-effects of L-DOPA.



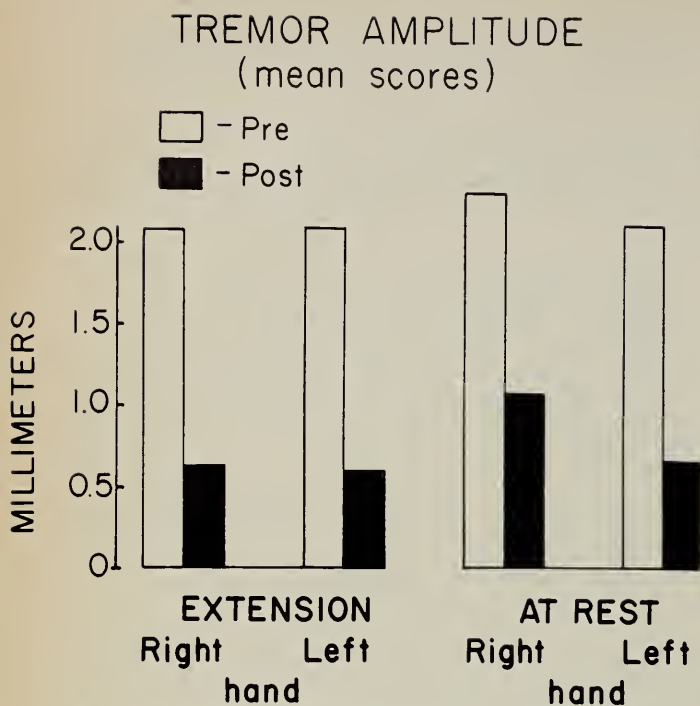


Fig. 2. Effect of L-DOPA administration on amplitude of tremor.

tors participating in the Eaton Laboratories Co-operative Study. Since a cumulative score is obtained at each evaluation, the percentage change in an individual patient can be readily determined by applying the simple formula:

$$\frac{\text{Pretreatment score} - \text{Current score}}{\text{Pretreatment score}} \times 100 = \% \text{ Improvement}$$

A typical series of such evaluations for an individual patient is shown in Table 4.

Additional measurements were made of each patient as to tremor and speed of movement using standardized activities. Psychological testing of each patient was also performed. Retesting in each area was carried out after treatment with levodopa when the patient was felt to have reached a therapeutic level of the drug.

Figure 2 shows the changes in amplitude of tremor in both hands while arms were extended and at rest. In each case these differences were statistically significant and demonstrate nearly 50% reduction in amplitude. This figure as well as the next four show the results of analysis of data of our first 46 patients.

Figure 3 displays tremor frequency measured in *cycles per second*. Parkinsonian tremor is considered to fall within the range of 4-8 cycles per second. Normal tremor generally lies in the 10-14 cycle per second range. Increase in frequency therefore reflects a trend toward "normal" and while small increments are noted in each case, these were statistically significant.

Figures 4 and 5 show the improved performance on tasks which measure speed of movement. Patients are asked to walk a measured distance; to pick up a series of coins with the right hand and then the left hand; to put on a laboratory coat and button it; and finally to vocalize a tone for as long as possible. Normal values for each of these activities are noted above each graph and it is obvious that despite the marked improvement in various functions, the patients did not as a group perform at normal speed. Individuals often displayed a return to normal values and further analysis of performance on these tasks after the group has been under treatment with L-DOPA for several months will unquestionably show even greater improvements. It should be noted that the test "duration of vocalization" is also improved since this simple measure of effective lung capacity reveals increased volume with a longer expiratory phase.

Certain of the psychological test results are displayed in Figure 6. The Wechsler Adult Intelligence Scale is a standard test which was administered to every patient. It should be noted that there is a 15 point difference between performance on the verbal as compared to the perceptual and perceptual-motor (performance) portions of the test. This reflects at least two factors; a mild to severe chronic brain syndrome seen in many elderly patients; the difficulty patients experience in drawing figures, etc., due to tremor, rigidity, akinesia, etc., while working against time. In every instance, including the results of the Wechsler Memory Scale, a significant improvement in intellectual function is noted. There are several possible explanations for this phenomenon. We can safely exclude the possibility that we are recruiting additional neurons. One theory which we feel quite likely is that, as the patients begin to feel better physically, move about more easily and regain independence in A.D.L., and socialize more, they become more highly motivated, less apathetic and more eager to work harder and perform better. An in-depth study of this and other possible factors is underway at present.

### Side-effects

Brief mention should be made of various side-effects of L-DOPA treatment. It is the rare patient who completely escapes without experiencing one or another of the attendant problems of this therapy. Table 5 summarizes the more

Table 4. Sequential Evaluation of an Average Patient

	Scores			
	7-15-69	7-26-69	10-27-69	2-9-70
Neurological Examination				
Mental status	0	0	0	0
Postural stability	3	1	0	0
Sialorrhea	1	1	0	0
Sweating	1	0	0	0
Facial expression	3	2	0	0
Bradykinesia	3	2	0	0
Finger dexterity				
Right hand	3	2	1	1
Left hand	3	3	1	1
Tremor				
Right upper limb	1	0	0	0
Left upper limb	3	2	2	2
Face, lips, etc.	0	0	0	0
Right lower limb	0	0	0	0
Left lower limb	0	1	1	1
Rigidity				
Right upper limb	3	1	0	0
Left upper limb	3	2	2	2
Neck	3	0	0	0
Right lower limb	2	0	0	0
Left lower limb	2	0	0	0
Posture	2	1	0	0
Total	36	18	5	5
Northwestern University Disability Scales (A.D.L.)				
Walking	3	2	0	0
Dressing	2	2	0	0
Eating	2	1	0	0
Feeding	2	1	0	0
Hygiene	3	2	0	0
Speech	0	0	0	0
Total	12	8	0	0
Grand total	48	26	5	5
L-Dopa dose, g/day	0	2.0	3.5	4.0

common side-effects. In our series, approximately 55% of all patients experienced some problems related to the gastrointestinal system, usually nausea and rarely vomiting. The severity of these symptoms has been much less at present than at the beginning of the study since we institute treatment at a slower pace now. When nausea or vomiting has been severe, the dose has been reduced for a couple of days, then slowly advanced. These symptoms often have been transient, lasting a day or two and frequently developed after a dosage increase. It has also been found that the most common time for nausea and vomiting is in the morning after breakfast. Elimination of coffee and citrus juices from the diet frequently eliminated the nausea in a high proportion of the patients suffering from this symptom.

Almost 70% of the patients seen during the early phase of our study displayed symptoms referable to the central nervous system. This proportion has dropped to approximately 50% at present, a result of the more conservative treatment program now in use. These central nervous system symptoms fall into two broad categories. The first consists primarily of transient confusional states, as in an acute toxic brain syndrome, and invariably has been seen in the elderly patient. Rarely did overt psychosis develop, although when this did occur it was usually of a paranoid type. Reduction in dosage cleared the symptom and only one patient of our entire series was removed from the study because of mental symptomatology.

The second category of CNS symptoms includes spontaneous adventitious movements which can appear at any dose level although usually at 4.0 g/day or higher. Most often these movements have been an orolingual athetosis or grimacing; choreiform jerks of the shoulder, arm or foot; athetoid inversions of the foot, frequently while attempting to walk; torticolliform head and neck twisting; or irregular respiratory movements seemingly due to dystonic diaphragmatic movements. In every case these movements were abolished by reduction in total daily dose, but occasionally this resulted in sub-optimal levels of L-DOPA. It has been found that haloperidol (Haldol) in small divided doses can often control these new extrapyramidal movements without inter-

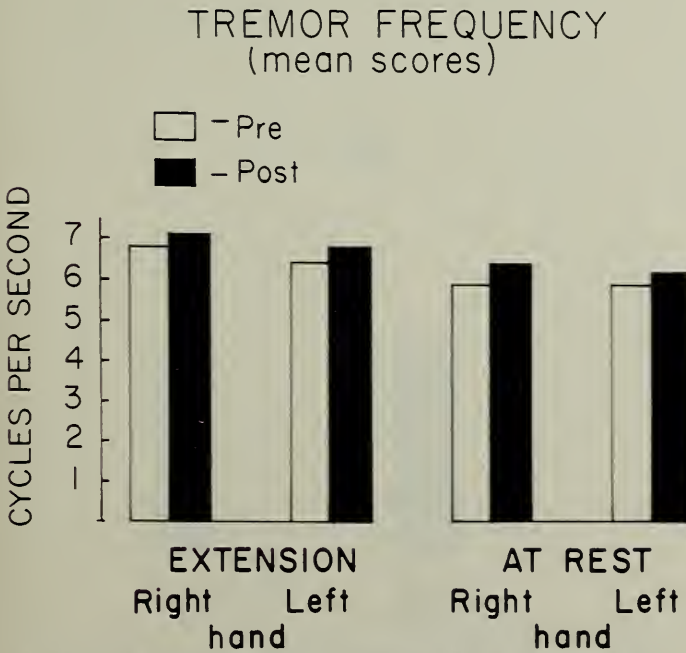


Fig. 3. Effect of L-DOPA administration on frequency of tremor.



# TESTS OF SPEED OF MOVEMENT (mean scores)

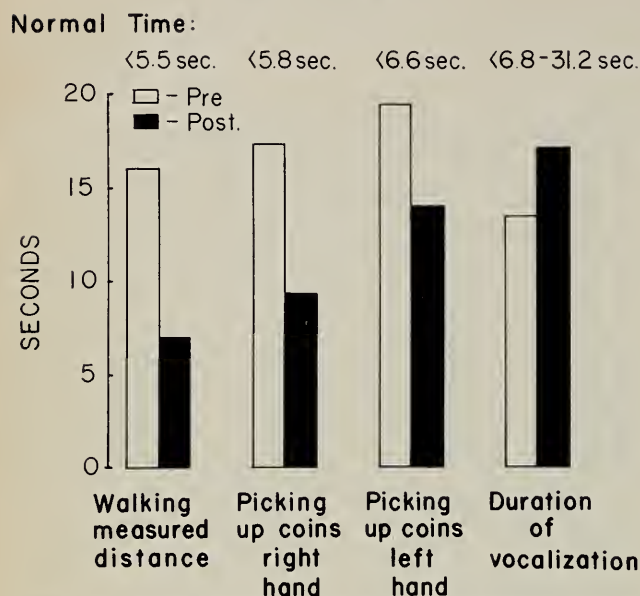


Fig. 4. Speed of performance of movements before and after treatment with L-DOPA.

Table 5. Side Effects of Levodopa Treatment

## Gastrointestinal System

Nausea and/or vomiting  
Anorexia  
Constipation or diarrhea  
G. I. Bleeding

## Central Nervous System

Hyperkinesias  
Mental confusion  
Psychosis  
Dreaming  
Drowsiness or agitation  
Depression

## Cardiovascular System

Orthostatic hypotension  
Dizziness and light-headedness

Tachycardia  
Syncope

## Miscellaneous

Purple urine  
Myalgia  
Malaise  
Dependent pedal edema  
Hypersexuality

Urinary color alteration has been noted by a few investigators and is a dramatic, if totally harmless occurrence. The urine of certain patients tends to develop a deep burgundy color which darkens upon standing. Analysis reveals no blood or myoglobin; it is not associated with infection, hydration, or specific dietary intake. Brief biochemical analysis<sup>17</sup> revealed the colored substance to be some type of hydroxyquinone which appears as a levodopa metabolite in certain individuals. Its appearance, especially in incontinent patients, can often elicit the conclusion that hematuria exists and can lead to extensive and unnecessary urological workup until the true nature of the disorder is ascertained.

The symptom of hypersexuality which was accorded considerable notoriety in the popular press is, in fact, a side-effect which occurs in probably 1% or less of all patients. In our series the incidence is 0.8%. Rather than reflecting a truly aphrodisiacal property of L-DOPA, it occurs in elderly males who develop a confusional brain syndrome, and released from the previous physical impediments of their disease, impulsively and irrationally pursue any human female object (nurse) or bedevil their wives as if to recapture those lost and irretrievable moments of the preceding years.

# TESTS OF SPEED OF MOVEMENT (mean scores)

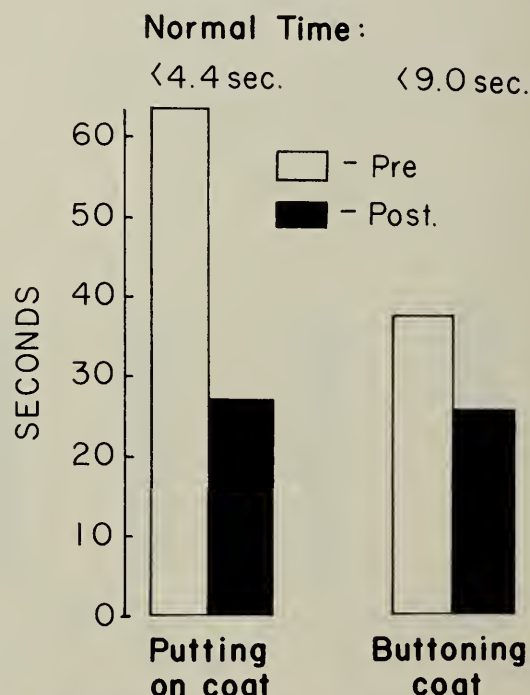


Fig. 5. Speed of performance of movements before and after treatment with L-DOPA.

fering with the therapeutic effect of levodopa.

Hypotension, usually orthostatic, has occurred in a small but significant number of patients in various studies, and has occasionally resulted in syncope. The incidence in our group is very small and only one patient was removed from the study because of persistent symptomatic hypotension.

## PERFORMANCE ON PSYCHOLOGICAL TESTS (mean scores)

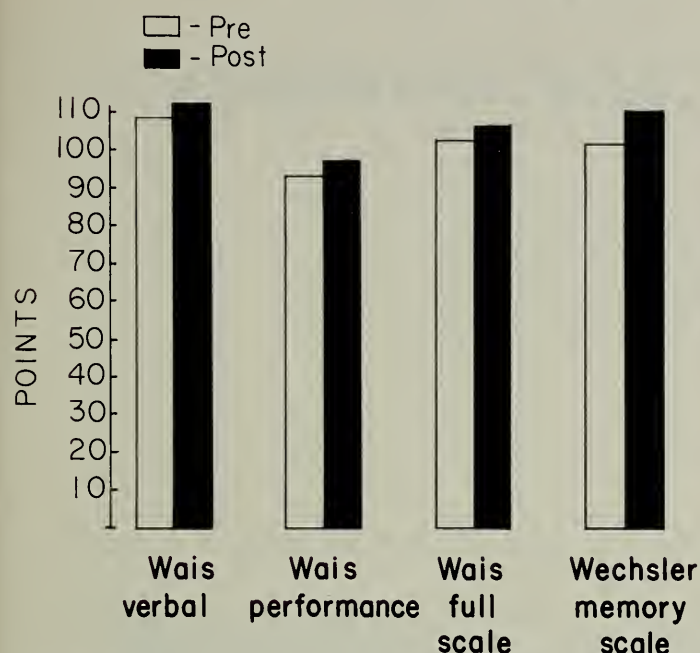


Fig. 6. Effect of L-DOPA administration on psychological test performance.

### Rehabilitation methods

Rehabilitation of the parkinsonian begins the moment he enters the hospital. The milieu of the neurological floor is such that independent function in all areas of activities of daily living is stressed. Regardless of age or severity of illness, each patient is permitted and encouraged to try to wash himself and perform dental hygiene in the morning; to feed himself, with fingers if necessary; to dress himself; to ambulate independently, etc. Much time was needed when the program began to train the ward personnel *not* to feed, wash or dress the patient in order that the task be finished quickly. No patient is permitted to go hungry, dirty, or not have his clothing changed just to prove a point. Where help is definitely needed it is provided. The transition from infantile dependency at home to independence in the hospital is frequently fraught with psychic trauma but almost every patient has been able to make the change, only rare exceptions refusing to give up their dependent status. The notion of again becoming "as he once was" appeals to the patient and comes to be a motivating force.

The patients are encouraged to become active on the ward and socialize with each other. If any patient is seen or heard shuffling down the hall, any of the staff from housekeeper to nurse to physician gently chides him and reminds him of how he should walk. A friendly social climate develops on the unit with great camaraderie among all patients who aid and encourage each other.

A major component in rehabilitation is the physical therapy program which has evolved. This is a group program which stresses restoration of natural body movements, reciprocal movements of limbs, correct posture and trunk stability, balance and gait. Every patient is placed into the group, regardless of his age, severity of disease or mental status. Individual physical therapy is administered only to those patients with marked contractures who need their muscles stretched in order to improve range of motion about the joint. None of the "traditional" passive limb stretching, whirlpool and massage programs are carried out any longer for several sound reasons. It is an uneconomical use of time and staff to work on a one-to-one basis and unfeasible when ten to fifteen patients must be treated daily. More important, however, is the fact that such individual treatments tend to encourage and propagate the dependent status of the patient, which defeats all our goals. It must also be recalled that treatment with L-DOPA makes many changes in the parkinsonian. The drug loosens him and permits him to speed up. As muscles relax, joints become more mobile. Posture improves, stability and balance return. A program which stresses normal movements of limbs and trunk is necessary to help the patient relearn patterns which have become suppressed over time due to the relentless distortions imposed by the disease. An added benefit is found in the social aspect of having the entire group together in a semi-circle about the leader. The typical Parkinson patient tends to withdraw from social contact; in the therapy context he is forced to join in and soon learns that he is acceptable to his peers. Finally, each patient attempts to surpass his neighbor in skill or speed of performance.

*The second part of this article will cover the areas of "Rehabilitation methods," "Case studies," and a discussion of L-DOPA in relation to parkinsonism.*



# Refractory psoriasis

## —a new approach to the management

By J. W. YARBRO, M.D. PH.D., AND ULLIN W. LEAVELL, JR., M.D./KENTUCKY

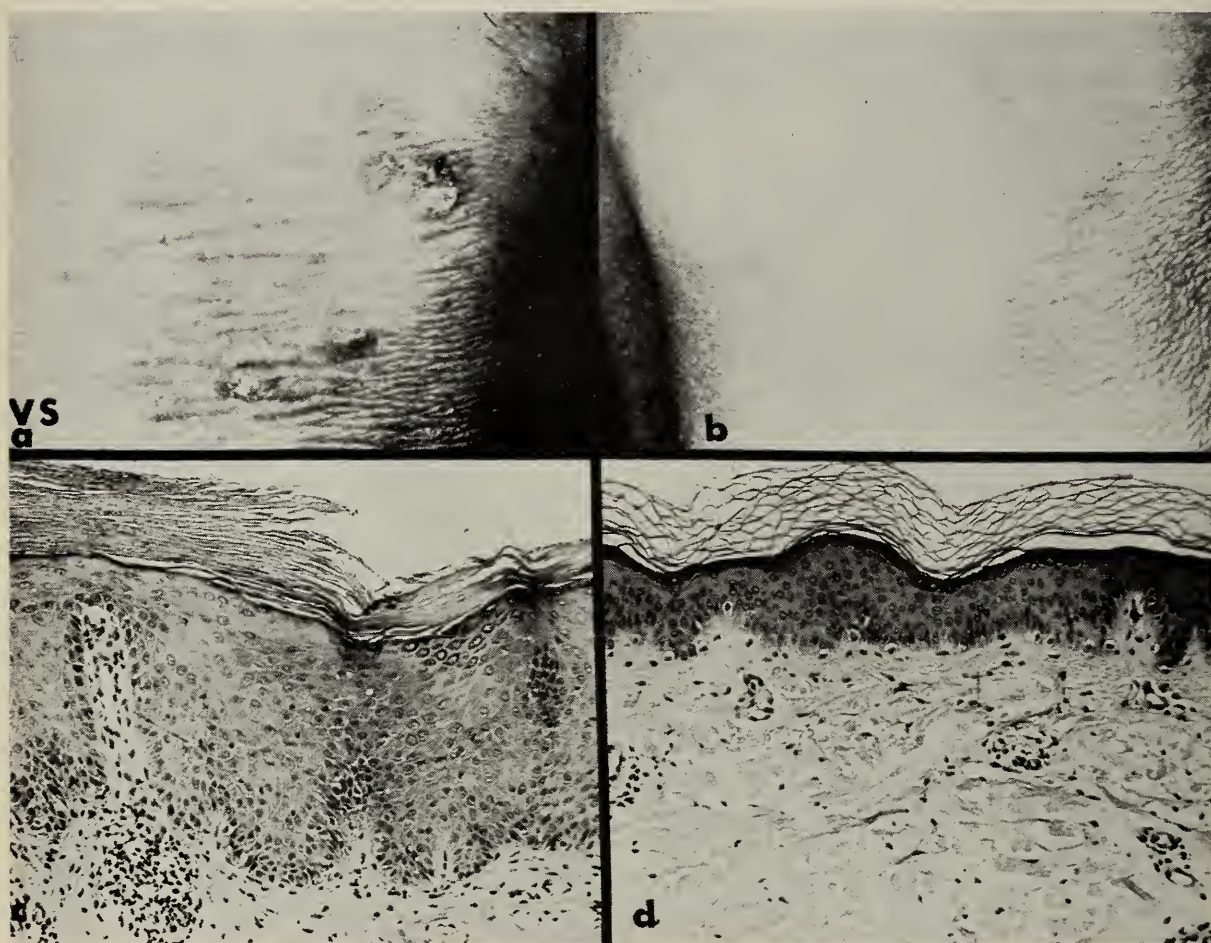


Fig. 1. (a) Typical skin lesion on knee prior to therapy. (b) Same lesion after four weeks of therapy. (c) Biopsy of a lesion prior to therapy. (d) Biopsy after four weeks of therapy.

*\*This investigation was supported in part by United States Public Health Service Research Grant No. CA 11266.*

Although often mild, psoriasis may, on occasion, produce an incapacitating dermatitis which is refractory to conventional therapy. Furthermore, the emotional reaction, especially of the female patient, may in itself be far out of proportion to the extent of involvement. Therefore, on occasion, in selected patients, one may justify the use of a therapeutic agent which carries more than the ordinary risk of side effects. One such agent, methotrexate, a folic acid antagonist has been widely used since 1951, when Gubner<sup>1</sup> fortuitously discovered that psoriatic skin lesions cleared in a patient treated with aminopterin.

Unfortunately, the margin of safety with the folic acid antagonists is narrow, and undesirable side effects may occur with doses near, or slightly in excess of, therapeutic levels. Patients have been reported to develop leukopenia, thrombocytopenia, mouth ulcers, vomiting, burning of the skin, and abnormal liver function. Hair loss, hepatic fibrosis, cirrhosis, and pulmonary disease have also been reported.

Although these complications involve only a small percentage of patients receiving methotrexate, their degree of severity has led to a serious re-appraisal of the use of such a potent antimetabolite for a benign disease.<sup>2</sup> We investigated hydroxyurea because it may offer an advantage over methotrexate in terms of toxicity.

Although hydroxyurea was synthesized a century ago, it was not until recently that it was shown to be an effective anti-tumor agent. Hydroxyurea is a selective inhibitor of DNA synthesis<sup>3</sup> and this effect is rapidly reversible after therapy is discontinued so that the reduced white blood count produced by large doses returns promptly to normal. Side effects have been minimal and platelet depression is less than with other chemotherapeutic agents. Hydroxyurea has been shown to be effective in chronic myelogenous leukemia,<sup>4</sup> polycythemia vera,<sup>5</sup> and melanoma.<sup>6</sup>

During the course of long-term therapy of chronic myelogenous leukemia with this agent,

a peculiar thinning of the skin of the dorsum of the hands was noted by Kennedy.<sup>7</sup> This observation, together with the effectiveness of methotrexate in psoriasis, led to a trial of hydroxyurea in psoriasis. The first two patients selected for study in 1965, showed a dramatic response to therapy.<sup>8</sup> This led to controlled double-blind clinical trials. These clinical trials, recently reported,<sup>9</sup> demonstrated hydroxyurea to be effective in nine of ten cases with refractory psoriasis as determined by clinical examination and serial skin biopsy. Maximal clearing was usually seen after about six weeks of therapy with hydroxyurea at a dose of 0.5 gm b.i.d. When hydroxyurea was stopped, there were no rebound phenomena.

In over twenty patients treated to date, there have been no toxic manifestations referable to the gastrointestinal system, liver, or kidneys. White blood count, hemoglobin and platelet count in patients receiving hydroxyurea at a dose of 0.5 gm b.i.d. did not significantly decrease either in the average or the final value over a four-week course.

Figure 1 shows a typical lesion before and after therapy and the histopathologic changes in this patient. Following hydroxyurea, all but one of the ten cases biopsied showed decreased hyperkeratosis, parakeratosis, mitotic figures and thickness of the epidermis.

Hydroxyurea is rapidly excreted in the urine, but a significant amount of the drug is metabolized. Its rapid absorption and lack of toxicity to the gastrointestinal tract permit oral therapy. The drug is teratogenic<sup>10</sup> and some impairment of renal function has been seen at high dose levels,<sup>11</sup> but there have been no reports of liver toxicity, pulmonary fibrosis, or neurotoxicity. Hydroxyurea has, as its major toxic manifestation, depression of the bone marrow, but the platelet count is relatively less affected than is the white blood count, and a distinct advantage of the drug is that recovery from bone marrow depression is usually rapid when hydroxyurea treatment is interrupted.



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**ULLIN W. LEAVELL, Jr., M.D.,** (not shown) is associate professor of medicine and dermatology at the University of Kentucky, College of Medicine. He received his M.D. from Duke University. Dr. Leavell is on the staffs of several Lexington hospitals and author of numerous articles on dermatology.



Studies in the mouse<sup>12</sup> have indicated that hydroxyurea is a potent inhibitor of DNA synthesis in the skin. Van Scott *et al.*<sup>13</sup> showed increased mitotic figures in the epidermis of psoriatic patients, a volume of epidermis approximately four times normal and dermal papillae extended over three fold. Psoriasis, therefore, might be expected to respond to drugs which suppress epidermal hyperplasia, and thus it is not surprising that hydroxyurea, a specific inhibitor of DNA synthesis, should have this effect.

Finally, a note of caution: Hydroxyurea is a potent metabolic inhibitor and the absence of significant clinical toxicity to date does not preclude the possibility of complications if this agent is used indiscriminately in large numbers of patients. Psoriasis, regardless of its toll in human physical and mental suffering, remains a benign disease. Hydroxyurea, like methotrexate, should be used only in refractory cases, under careful observation of white blood count and other parameters, never in a woman who may become pregnant or a man who may father a child while on therapy, and only after a careful explanation to the patient of the potential risks associated with antimetabolic therapy and the fact that such therapy is new and not standard.

### Summary

Hydroxyurea is an effective agent in the treatment of refractory psoriasis. Rapid clinical improvement and a decrease in epidermal thickness on biopsy is seen. The drug is well tolerated in a dosage of 0.5 gm, twice daily. In no case has the drug been stopped at this dose level because of toxicity even though in some cases therapy has been continued for up to nineteen weeks. If hydroxyurea proves less toxic in prolonged use than methotrexate, it may provide a valuable tool for the management of severe psoriasis. Comparison of hydroxyurea and

methotrexate as to their efficacy and safety is now indicated.

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## Why Business Firms Flee

Businessmen from throughout New York State want the legislature to abolish the law which permits payment of unemployment benefits to strikers, contending this is having an adverse effect on attracting new business. A spokesman for the Associated Industries of New York State testified that the state lost 19,200 manufacturing jobs between 1959, and 1969. 11,800 of them during 1969, alone.

## *Expansion of a local effort*

# The MECO Project

BY LEE A. FISCHER/SAMA

During the summer of 1969, the Student American Medical Association sponsored a medical student summer job-education project in cooperation with the Illinois State Medical Society, the Illinois Academy of General Practice, and the Illinois Hospital Association. Programs were established in 26 community hospitals around the state of Illinois with positions for 70 freshman and sophomore students. The Medical Education and Community Orientation (MECO) Project was designed as an integral part of the total medical education process, with a basic educational motivation and orientation. The utilization of practicing physicians and community hospitals in the preclinical education of medical students was the basic underlying concept of this project.<sup>1</sup>

**D**uring the summer of 1970, a total of 141 students in Illinois, (plus 45 in other states) 1,019 physicians, and 80 hospitals, participated in the project in Illinois, Iowa, Michigan, Wisconsin and Ohio. The expansion of the MECO Project was funded under an administrative grant from the Sears Roebuck Foundation. The program consisted of a general orientation to a community hospital for pre-freshmen and pre-sophomore medical students via a rotation through numerous areas of the hospital and the surrounding community. The students spent time in ICU, surgery, anesthesiology, physicians' offices, hospital administration, nursing homes, etc. Of 30 possible areas, students rotated through an average of 20 different areas dur-



*Photo by Quincy Herald-Whig*

### Preparing for surgery

Frank E. Burkett, Northwestern University medical student, assists Miss JoAnn Carlson in the operating room of Blessing Hospital in Quincy.





### Attending an emergency victim

Ed Unger, University of Illinois medical student, observes as Dr. Ed Ulrich examines an emergency room patient at the Abraham Lincoln Memorial Hospital in Lincoln.

ing the ten week summer program. One physician at each hospital acted as MECO program coordinator.

Based on an extensive evaluation<sup>2</sup> which included students, physician program directors, and hospital administrators, a number of conclusions was reached regarding the MECO Project.

Students overwhelmingly agreed that the five goals of the Project were met:

- to introduce the medical student to the total scope of health care in a hospital setting and to the operation of a hospital in a health care delivery system.
- to relate differing aspects

of hospital operation to specific patients in a total picture of medical treatment.

- to increase the level of awareness about the changing nature of health care delivery in the hospital setting, e.g. use of new technical equipment, methodology, and personnel.
- to introduce the pre-medical student to the clinical aspects of medicine in a hospital setting.
- to reinforce learning in

the first year of medical school by relating specific information to clinical medicine, e.g. anatomy, biochemistry, physiology.

Other conclusions revealed that 70% of the participating students professed interest in returning to their MECO hospitals for future practice. The continuity of the program, which depended to a great extent on the recommendations of participating students, was assured by the response of 143 of 146 students in recommending the program

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Lee A. Fischer is a third year medical student at the University of Illinois College of Medicine. He is presently chairman of the MECO Coordinating Committee, and a member of the Board of Trustees, Student American Medical Association.

to their fellow students. The MECO programs could have a tremendous potential effect on continuing education of physicians as demonstrated by the effect of physician involvement in the educational process of the programs. Further conclusions and supporting data are presented elsewhere.<sup>2</sup>

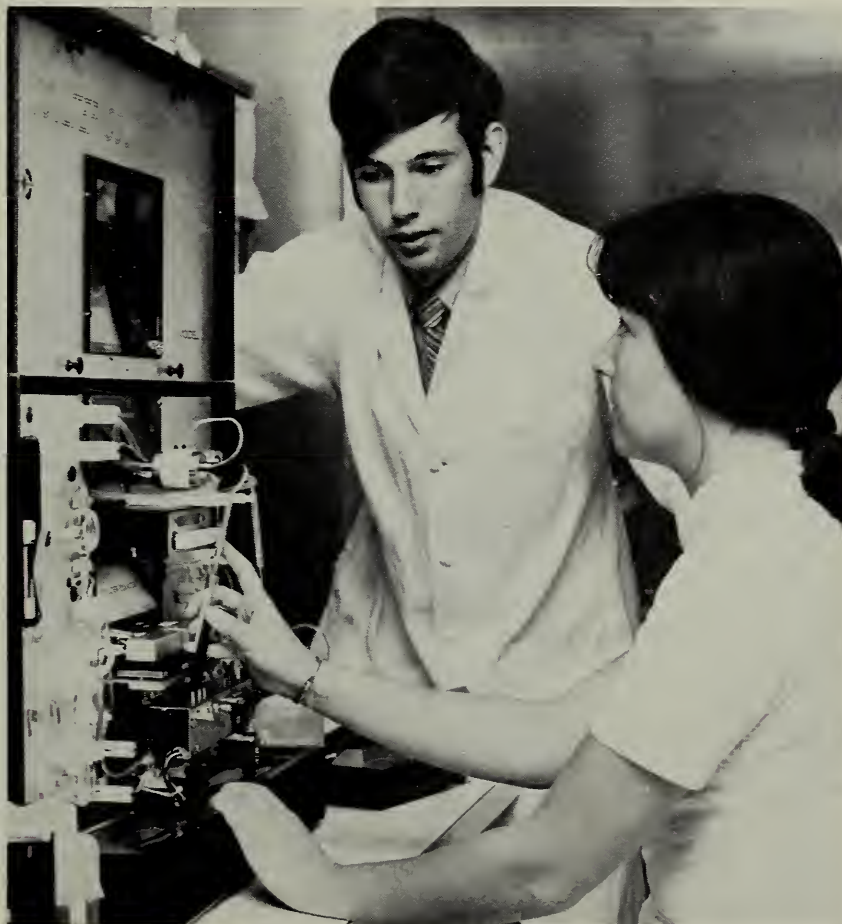
Since the completion of the 1970 MECO Project, efforts have been directed toward expanding the project to include more students and hospitals in existing states and developing programs in new states. By summer 1971, either pilot or full programs will be function-

ing in the states of Illinois, Iowa, Michigan, Indiana, Ohio, Pennsylvania, California, Florida, Hawaii, Louisiana, Missouri, Mississippi, North Dakota, South Dakota, Puerto Rico, Texas, Wisconsin and New York.

The MECO Coordinating Committee, composed of the student program director from each state, sets overall policy for the project. However, within this national body, each state is autonomous, as numerous factors vary from state to state. The national Coordinating Committee has developed a set of goals and objec-

tives for use by hospitals planning MECO programs. Specific educational objectives to fulfill various goals and needs are being developed for each area of rotation. Both the educational and general orientation aspects of the hospital and community are being stressed. The Committee feels that with good educational planning, both the education and orientation aspects of the programs will be strengthened so that students and hospitals alike will benefit further from the experience.

The MECO Project has also served to establish close rela-



*Photo by the Belleville News-Democrat*

## Running through a blood sample

University of Illinois medical student, Robert Highly, from Belleville, observes medical technologist, Bonnie Hellrung running a blood sample through a computerized "Coulter Counter" at Belleville's Memorial Hospital.





Photo by The Pantagraph, Bloomington-Normal

## Pointers in pediatrics

Dr. Kenneth Calhoun (right) makes his nursery rounds with Richard C. Trefzger, a University of Illinois medical student at Brokaw Hospital in Normal.

tionships between local SAMA chapters, state medical societies and the state hospital associations. For the successful operation of the MECO program, all three organizations must cooperate to the fullest extent. Once these organizations began working on the program many states expanded their involvement to include other activities of the medical societies. For example, two and one-half years ago only two to three students were involved with the ISMS in establishing a MECO program. At present, representatives from all five Chicago medical schools sit on various ISMS committees, attend the ISMS annual session, the AMA sessions, and elect a full delegate to represent them in the ISMS House of Delegates.

At their 1970 clinical session in Boston, the AMA House of Delegates voted to "strongly support" the concept of the

MECO Project and to study the entire area of extramural educational programs. Other AMA

and AAMC councils and committees have done much the same.

Approximately 1,000 medical students will participate in the project in 18 states. Informal contacts are continuing in new states so that by summer 1972, hospitals and students in every state will have a chance to participate in a MECO program.

For further information on this Project contact Student American Medical Association, Division of Medical Education, 2635 Flossmoor Rd. Flossmoor, Ill. 60422.

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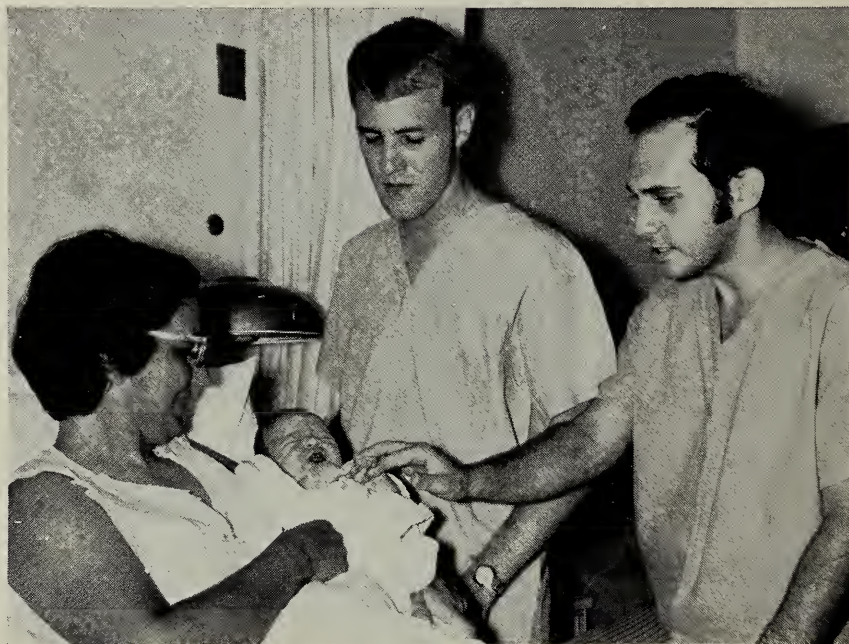


Photo by ARGUS

## A maternal reward

Even Kvelland (left), University of Illinois medical student from Somonauk, and Alan Resnick, a medical student at the University of Mexico, from Aurora, admire their "morning lesson" in the maternity ward at Hammond-Henry District Hospital in Geneseo.



*"And I said of medicine, that this is an art which considers the constitution of the patient, and has principles of action and reasons in each case."*

*Plato: Gorgias*

# The "art" of medicine

BY J. ERNEST BREED, M.D., ISMS PRESIDENT

Throughout the ages the motivation of the young student to become a physician has been an innate desire to aid those who are ill. Since admission to medical school today is in large part based upon grade averages and since between ten and forty per cent of those who graduate do not practice medicine, but embrace administration, research, or teaching, one wonders if the desire to aid the sick patient is still the motivating force for all those who gain entrance into medical schools.

The scientific explosion has markedly enhanced that portion of medical practice that Plato described as "principles of action and reasons," but that part "which considers the constitution of the patient" seems to be submerged. Today the average sick patient is attended by a number of specialists, none of whom he really gets to know and few of the specialists stop to consider "the constitution" of the patient.

The complaints of many patients are due to emotional disturbances. Because of fear, even those with organic disease may do poorly in spite of correct treatment. Friendliness and understanding instill patient confidence and confidence is essential if the patient is to do well. It is useless to have the correct diagnosis if the patient neither believes it nor takes the prescribed medicine. In the practice of medicine today, one of the greatest needs is more emphasis upon that "human" portion of the art, call it what you will, a bedside manner, empathy, understanding, or sympathy.

Actually the "compensation" received by a physician is in two areas—financial return and respect, of which the latter is far more important. He can get along with little money, but he must have the respect, confidence, admiration and affection of his patients. He hates to lose a patient—not because of the lack of income, but for the patient to reject him and transfer his confidence and loyalty to another doctor is an affront the first physician finds difficult to withstand.

To be a general practitioner requires more talent than to be a specialist. Not only must the generalist be informed in all branches of medicine, but he must have empathy for his people since his success depends upon his earning their respect and confidence. The patient initially has faith in the specialist to whom he is referred, only because his "family doctor" has assured him this specialist is competent.

The dissident student criticizes the medical profession for coldness and lack of concern for his fellow man. Since his only experience has been in the ivory tower, where the pursuit of excellence is paramount, he does not realize that the average physician has great personal empathy for his patients.

Those who would socialize medicine know it is necessary to discredit the medical profession in order to gain public support for federal controls. A strange paradox exists, however, in that those who have a "personal" physician may believe some of the propaganda about the profession, but they know their own physician is above reproach.

The American Medical Association, realizing the apprehensive patient may do poorly, has enlisted the assistance of the clergy to help provide "total care" for the troubled patient. Under the guidance of Paul B. McCleave, L.L.D., the Department of Medicine and Religion has greatly aided in the care of sick patients all over the country.

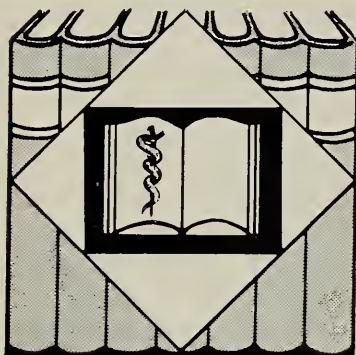


The clergymen cannot relieve the physician from his need to practice the "art" of medicine, but can augment his efforts or give some help if the physician is negligent.

The mechanism of the distribution of medical care is destined to undergo great change in the immediate future. The shortage of physicians will require more allied help assistants and the utilization of efficient business methods with doctors working together in multi-disciplinary groups. Re-emphasizing the coming change is the revelation in our student, intern, resident questionnaire that the great majority of our doctors in training are planning to join a group practice unit. In other words, if you want young doctors in your area, your chances are much increased if you organize existing physicians into groups.

Those who oppose group practice maintain that physicians in groups are "impersonal" or in other words are defective in the "art" of medicine. This need not necessarily be true and physicians in group practice should make an effort to be sure that each patient has a "personal" physician. One would believe "generalists" would be the most important specialists in such groups.

I would encourage physicians to take a second look at their bedside manners. Can it be that our concentration on the scientific part of medicine causes us to neglect the "art?" I would urge the doctor's wife to reflect on her husband's understanding and consideration for his patients. It may well be that due to fatigue or an inability to spend much time with individual patients, at times he is negligent in the consideration of the patient's "constitution." ◀



## the doctors library

**Urinary Tract Infection in Childhood and Its Relevance to Diseases in Adult Life.** By Victor Smallpiece, M.D. C. V. Mosby, St. Louis. 171 pp., illus., \$9.50.

This is a good, comprehensive review of urinary tract infections in childhood. Urinary tract infections are one of medicine's major unsolved problems. The chapter on etiology is thorough with an excellent section on the relation of reflex infections. The discussion of bladder with obstruction as a rare cause of urinary tract infection leaves out several important American references on this subject. The chapters on treatment and prognosis are up to date. This book is a valuable addition to any pediatrics library.

Harvey Kravitz, M.D.

**Current Pediatric Therapy 4.** By Gellis and Kagan.

This book revises and updates new and addi-

tional material in the area of pediatric therapy. The authors have incorporated material from over 100 new contributors and a number of new articles are added, covering numerous subjects.

Most childhood illnesses require little or no specific medication. It is also recognized that overtreatment is more often the rule than the exception.

It is the attempt of the authors to point out this pitfall and give detailed data in treatment for those diseases that actually need specific medication and management.

L. Martin Hardy, M.D.

**Essentials of Gastroenterology.** J. Ned Smith, Jr., M.D. The C. V. Mosby Company. St. Louis, 326 pages (Illus.) 1969.

This small text evolved from a mimeographed outline utilized in teaching clinical gastroenterology at the University of Missouri School of Medi-

cine. The purpose of the book is to present a brief account of the etiology, diagnosis and treatment of various disorders of the gastrointestinal tract. The material is fundamental and from this standpoint does accomplish the stated purpose. Unfortunately, however, one feels uncomfortable with the text as the total objective is considered.

Organization is traditional and includes 16 chapters. The first chapter on "Gastrointestinal History" is well placed and deserves emphasis in such a book. The neophyte will not appreciate the emphasis devoted to the psychiatric aspects of gastrointestinal symptomatology. The longest chapters are devoted appropriately to neoplasms, ulcerative colitis and peptic ulcer. Selected radiographs are presented throughout and are excellent. Motility data receive written commentary but no illustrations are presented. Endoscopic findings are described in some detail but the relative importance of endoscopy itself seems to be over-emphasized in an introductory text.

Much of the valuable information referred to seems to be uncomfortably smothered in numerous quotations, both in and out of the text itself. The relevance of many quotations is questionable and others detract from the material presented.

At times, relatively insignificant points are discussed in detail without an opinion expressed by the author. In addition, categorical statements of unconfirmed opinions are made without satisfactory defense or condemnation. A number of experimental observations are included which do not bear specifically on the clinical discussion.

The chapter bibliographies are satisfactory and proposed to serve the student in his further quests. A 15-page index is adequate.

The difficulty in writing a concise text for the medical student or young physician is real. I do not believe this was accomplished by Smith.

Ivan C. Keever, M.D.

**Crisis Fleeting**—Original Reports on Military Medicine in India and Burma in the Second World War. Compiled and edited by James H. Stone.

CRISIS FLEETING is a highly personalized account of the forgotten theatre of operations. Professor Stone has made available his manuscript, collected as a Medical Service Corps Officer and Military Historian. The account of the hardships, frustrations and individual experiences gives the reader a fascinating insight into the daily lives of people thrown into this conflict from the peace and quiet of lives in an entirely different environment.

There are five "books" in all; "North Tirap Log" from a day to day record kept by several Medical Department enlisted men; "Chinese Liaison Detail" by Walter S. Jones, M.D., a GYN-OB specialist; the diary of Col. John M. Tamraz, M.D., Regular Army SOS surgeon; "With Wingates Chindits" by Maj. General W. J. Officer of the British Army; and "The Marauders and the Microbes" by Drs. E. T. Hopkins, Henry G. Stelling and Tracy S. Vorhees, Col. J. A. G., USA.

North Tirap was a first aid station on a minor trail in North Burma. The trail was one leading from Assam Province, India through steep, heavily forested hills into the Hukawng Valley of Burma. Small motor vehicles could barely traverse the 15 miles between Ledo and Tirap but trucks could not.

Dr. Walter S. Jones describes his attack of scrub typhus, especially his delirium and hallucinations which are most interesting.

Col. Tamraz' diary is a well-kept history of his daily comings and goings. Tamraz was pulled out of his job as Surgeon SOS to be assigned to Lord Mountbatten's staff, only to be sent back to his old job before he got started on the new one. Col. Cooley was to replace Tamraz. This reviewer knew both Tamraz and Cooley, his SOS supposed replacement. Both were conscientious, fine men devoted to their jobs.

General Officer (Officer is his name) wrote a very interesting history of Wingates Chindits. Lack of medical intercommunications reduced medical personnel, and difficult evacuation of sick and wounded piled up trouble for the Chindits.

The last "book" contains the Vorhees Report. Col. Vorhees went to India to inspect the medical supply situation but could not help but look into a number of other things.

Capt. Hopkins, a battalion surgeon of "Merrills Marauders" (5307 Composite Unit), was very much dissatisfied with conditions in his unit. He sent a report to this effect through channels but gave Col. Vorhees a copy. Col. Vorhees looked into conditions mentioned but finally burned his copy of the report. The chapter, other than the Vorhees Report, is a description of the slow death of the Marauders. It was not the Japanese who knocked them out but amoebic dysentery, malaria, rickettsia and other infective agents.

This book is of great interest to all those who served in World War II, and I have no doubt that men and women who served in the India-China-Burma theatre will find it fascinating reading.

George F. Lull, M.D.



**T**he exposure of the physician as a target for legal actions against him have been increasing in the last decade. Other targets in malpractice have been in the institutions in which the physician works, primarily hospitals and clinics, and other employees of the institutions. However, the physician is the key target because he manages, directs, and is responsible for the patient care rendered throughout the United States.

In an age where people are referred to as numbers—Social Security, Blue Cross, hospital—due to the increase of computerization, many persons look to the doctor as one who cares about them personally, both mentally and physically. Even though they know the doctor is being paid to care, they develop strong personal feelings toward him, including love and hate relationships. Psychologically, people lash out at those they are concerned about.

Thus, the doctor is not anonymous or faceless. He is a real person and “the slings and arrows of outrageous fortune” are directed at him. Why is he singled out? Is it a disgrace or a tribute to be a target in this modern society?

Our overall objective, as practicing physicians, is to analyze the factors causing this situation. This will enable us to accomplish these following objectives:

1. Reduce the physician's vulnerability to malpractice claims and suits.
2. Eliminate some of the malpractice causes of action by professional education.
3. Improve the legal defenses of such actions.
4. Recommend legislative remedies to combat the increase of malpractice claims.

There are several types of legal actions which are referred to as “malpractice.” As you know, they are as follows:

- Contractual relations; breach of contract
- Negligence or civil liability
- Implied warranty of product and breach of warranty
- Assault and battery
- False imprisonment
- Libel and slander

The basis for these judgments are awarded as monetary damages.

We must take a fresh look at the nature and etiology of this type of disease, and then suggest several types of modern remedies. The factors that are the etiological agents today may not be the same as in the past.

There are five etiological factors:

1. Patient dissatisfaction
2. Patient's expectations not met
3. Unusual and non-anticipated results of treatments
4. Physician's critical attitude or prior treatment
5. Remunerative rewards to the attorneys for these types of legal actions.

#### **Patient dissatisfaction**

There is no doubt that the best preventive measure against malpractice actions is to develop good physician-patient rapport and relationship. This means that the doctor has to spend more time and consideration with his patients, or as much time as it takes, to maintain the patient's confidence and keep the lines of

## **The doctor as a target**

**“It is a paradox that a \$10.00 visit or a \$500.00 surgical fee can result in a law suit running into a million dollars...”**

communication open. No enterprise can survive with dissatisfied customers. A dissatisfied patient means poor public relations and the results can be obvious. They will surely fertilize any seed of malpractice action. When we talk about the patient, we also mean the family members that are concerned. In today's climate the doctor not only deals with the patient, but, in the case of minor or aged persons, certainly with other members of the family.

Since most of these causes of action occur in institutions of health care such as hospitals, nursing homes, or extended care facilities, good rapport must also be maintained with the many other allied health care and paramedical professionals that are interposed between the doctor and the patient. With the changes in medical practice, the loyalties of many of these employees are not wholeheartedly for the physician, but rather towards the institution. Therefore, they may feel free to criticize care and treatment, and raise doubts in the patient and the patient's family about procedures and occurrences. These individuals may be quite flippant, and may not be educated or bound by any ethical considerations in their behavior. They are ready to discuss the medical diagnoses and explanations of procedures without any prior authority or knowledge. Although these are seldom done with malice, the results, of course, are the same. Therefore, the doctor must have and maintain excellent rapport with his patient, the patient's family, and other health personnel involved with the care of the patient such as nurses, nurses' aides, practical nurses, therapists, and technicians.

Patient dissatisfaction occurs because of apprehension due to what is felt to be inadequate attention during the hospitalization. This reflects not only on the doctor, but very often occurs in the manner of admission, contact with personnel, discomfort in being transported from one area to another, and the lack of knowledge of what is happening. The patient feels very insecure in his bed. He is stuck, probed, shoved on a cart, and taken from one place to another. The patients are often kept waiting in limbo.

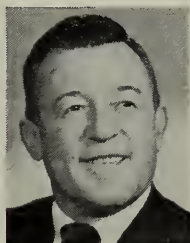
The handling and discussing of fees is an important and sensitive part of the doctor-patient relationship. A patient will usually accept the bill and make attempts to pay if he is aware of the circumstances. He may not pay the whole bill at once. We sometimes forget that the public is accustomed to paying for things on time and on credit. In any case, the fees and bills which are not explained and come as a shock to the patient, sometimes fertilize a potential malpractice situation. There is no substitute for good relationships with patients.

#### **Patient's expectations not met**

We live in an age of health miracles, when the public and our patients expect instantaneous diagnosis, cure, and treatment with immediate relief of their problems and a lot of optimism as to the results. Public relations of all types from drug companies and other health organizations for arthritis, multiple sclerosis, etc. have outpromised the deliverers of health care, thereby creating feelings of great dissatisfaction, disbelief,

## **in malpractice**

BY HERMAN WING, M.D., LL.B./CHICAGO



**HERMAN WING, M.D., LL.B., is director of Physical Medicine and Rehabilitation, Illinois Masonic Medical Center, clinical professor of PM&R, Loyola University Stritch School of Medicine, a member of the Board of the American College of Legal Medicine, a member of the Medical-Legal Council, Illinois State Medical Society, and chairman of the Medical-Legal Committee of the Chicago Medical Society.**



# "The physicians are easily identifiable targets;

and even fury, when, in fact, these unrealistic expectations are not met. Some patients even feel that they should be better and improved coming out of the hospital, than when they entered. We know that very often this is not possible. There is generally a long period of recuperation, convalescence, rehabilitation, and certain disabilities will sometimes result from the illness. The unrealistic expectations make some patients feel that they have even been cheated and they are bolstered in their ideas from the many periodicals and glib words of friends, TV, and pseudo physicians. Some patients may actually seek revenge. Stringent utilization procedures in hospitals whereby patients are not necessarily completely cured or treated, and are discharged at an earlier stage during the course of their illness also may be a source of dissatisfaction. Many patients do not understand the reasons for this, and again, this leaves them with a feeling of despair and disappointment.

Since this is the time and age of miracles when man goes to the moon and back, people expect that a new heart can be grafted, a kidney replaced, or some brain surgery done, and that they will be out and feeling better in several days playing tennis, football, or whatever other whim they may have in mind. There are probably patients who expect a tailor-made brand new set of clothes from the nursing stations to start life anew when they are ready to leave the hospital. Thus, we physicians are becoming the victims of a soap opera mental attitude about sickness and hospitalization. When we are not the hero, we may quickly become the villain.

## Unusual and non-anticipated results of treatment

We, in the profession, consider cardiac arrest, coronary attack during a hospital stay, blood clots, brain syndromes secondary to hypertension, hypotension, and wound infections as possible complications that are taken in stride. Even though everything possible is done to the patient at the time of diagnosis and occurrence of these conditions, nevertheless, the unusual result or disability may mean a lawsuit of large damages on the part of the patient. Unfortunately, we have drifted away from the necessity of proving negligence in most of these cases which makes it

rather easy for the patient's attorney. All he has to do with a complication and a serious result is to prove the facts of occurrence, and combine that with the sympathy of the jury, plus a few legal stratagems such as *resesipsa loquitor*. He can even use the physician's record as expert testimony against the physician. Thus, he is able to win cases. It has been reported that in 1969, there were four cases over a million dollars in this category.

It seems that many patients who sue will not accept anything less than a perfect result. In turn, they blame the physician for the patient's own frailties and lack of immortality.

## Physicians critical attitude of prior treatment

While this factor has been covered many times in the past, it keeps recurring frequently. During the evaluation of these types of cases, we find that quite often there has been a rather critical review of the patient's treatment by previous physicians and in previous hospitals. The patients may not understand and appreciate the alternative types of treatment and care, and so, this type of criticism may raise enough doubt in the patient's mind as to trigger a malpractice action. Criticism and critical attitudes are important in education, during clinical conferences, and other medical shop talks. While we all appreciate the competitive nature of medical practice, one must be mindful of improper and unethical remarks.

## Remunerative rewards for the attorneys

Malpractice today is big business for the legal profession. The physicians are generally well insured as well as enjoying high-standing and prestige in the community, not only from a social standpoint, but from an earning standpoint. The physicians are easily identifiable targets; they are personal and individualized. Because of the great demands of their time by patients and families for deliverance and utilization of health care, they are busy and are prone to settlement of malpractice actions. They can be coerced to "pay off" because their reputations are at stake, and such publicity, or even the idea of a mistake, is generally frowned upon. The hospitals and clinics are large multi-million dollar complexes and make for suitable additional targets.

## personal and individualized . . . ”

It is not difficult to intimidate and raise havoc with these institutions as they are quite impersonal and their assets do not belong to anyone in particular.

Regarding dollars and cents, the insurance premium today for the individual physician is on the rise. Since World War II, rates have risen at 3 times more than the cost of living, and in 1967 to 1969, the rates have increased 30% across the board in almost all states. There are instances now of premiums up to \$12,000 per year and the insurance industry expects to obtain premiums of \$4,000 per year from each physician in the near future.

It is estimated by the AMA that in 1968, the malpractice insurance premiums were 75 million dollars. The carriers paid 15 million dollars in commissions and sales expenses to obtain these premiums, leaving a net of 60 million. Ten million more were spent for costs of administration, miscellaneous taxes, items of expense of underwriting, etc. There were additional costs for claims investigation, and legal expenses amounting to 18 million dollars. It is estimated that approximately 35 million dollars will be paid to satisfy claims originating from medical services rendered in 1968, for an underwriting loss of three million dollars. Since the plaintiff's attorneys generally charge from 30 to 50% of their recovery, depending on whether they settle or go to trial, it may be estimated that malpractice claimants or the patients will recover a net of not more than 20 million dollars. This is out of an original 75 million dollar premium. The attorneys are actual partners in business with the plaintiff. There is no doubt that these figures show that the contingency fee of the plaintiff's attorney, in these malpractice cases, is a rather lucrative matter. It is difficult to attack this system at this time. Legislative remedies are frustrated because many of the state legislators are influenced by trial lawyers and their associations, both plaintiffs' and defendants'. The physicians are on the short end of the odds.

It is a paradox that a \$10.00 visit or a \$500.00 surgical fee for a procedure can result in a law suit running into a million dollars with half of it recovered by the attorney, and the rest going to the patient.

### Prevention

Some of the preventive measures to be taken to achieve our objectives can be briefly mentioned.

1. We should educate the physician in legal matters that are of importance to him through post graduate courses as well as in the medical schools. Then he will see the advantage of accurate and good records, as this is often his best defense against a malpractice action. Accurate and honest records go a long way to show an honest error in judgement which is non-actionable and will explain matters of unusual occurrence. This will allay any suspicion on the part of the jury that "the facts are being covered up."
2. This is the era of "consent." The doctrine of *Informed Consent* really means that the physician should be reasonable in explaining any type of procedure, especially, surgery or a complex diagnostic technique to the patient, and his family and the gross risks involved. The more he makes this a personal matter, and has some written record of it, the better protection he has. Blanket forms and blanket authorities for surgery will not stand up in a tightly contested case.
3. Safety programs in hospitals, institutions, and offices for any type of equipment and periodic courses for employees and other personnel are a plus in the defense of any law-suit.
4. The *Darling vs. Charleston Community Hospital* case in Illinois emphasized the benefit of consultation where unusual courses of treatment and complications occur. The physician can be strengthened and supported by another colleague who may have special education and training in the particular matter concerned.
5. There are many legislative remedies that have been instituted to decrease the claims and unwarranted benefits of malpractice. However, it is not practical to consider a complete elimination of the malpractice cause of action. These legislative remedies include the Alaskan statute which makes it a necessity to prove negligence in all such cases of malpractice. Other statutory proposals require the plaintiff to post a \$500 bond, have a separate trial on the Statute of Limitations, reimburse the plaintiff for hospital and medical



costs prior and during the preparation of the law suit without admission of liability on the part of the insurance carrier and the defense, protect the confidentiality, and keep immune from any discovery or deposition procedure, tissue committee reports, utilization committee reports, and audit committee reports, and similar peer-review mechanisms in hospitals and medical societies.

### Conclusions

A new approach for handling the growing numbers of malpractice suits, especially with the involvement of physicians as a chief target, should be found. Impartial Medical Testimony Panels, screening procedures, sometimes with the backing of the courts as the New Jersey plan, have been tried with questionable success. Various such panels as a pretrial mechanism have worked sporadically in the past. Arbitration procedures agreed to by patients on entrance to a hospital are being attempted in California and Ohio. To date, there has not been enough information to determine how effective they would be. They may have limited use under prescribed circumstances. Insurance of patients during hospitalization, a type of accident or "trip" insurance, sounds better than it will probably work because definitions of accidents and unusual complications have not been agreed upon.

A new approach to handle the load of cases to be considered is the utilization of professional individuals trained in both medicine and law with combined LL.B. and M.D. degrees. These individuals would be accredited by both professions, and would dispose of malpractice cases in a special judicial forum and act as a trier of fact. They would serve as referees or special judges. Duke University presently has a combined program in the Medical and Law Schools, educating such individuals. Other institutions, in both the fields of law and medicine, would be a prerequisite for these specially trained judges. There is established procedure for special hearings to dispense justice, such as referees in bankruptcy, the development of patent courts for complex technical matters, and IRS administrative boards. These special tribunals to handle the malpractice cases with their complex medical and health problems would generate additional public interest and stimulate expansion of our present educational and vocational facilities. The main objection is usually that a trial by jury is necessary for the adjudication of every legal dispute. However, the constitutional and inherent right

to trial by jury is applicable to criminal cases and not in civil cases.

These referees or judges would have the power and authority to adjudicate all types of problems with the complex medical and technical matters involving all aspects of the medical and health profession. They would also have the authority to call in expert witnesses to elaborate on any particular question. It may also be of interest to have ombudsmen serve within the courtroom to protect the claimant as well as other public interests.

These special tribunals could be organized by the courts of each state and these specialized individuals could maintain a circuit type court, if necessary, to cover the geographical areas of the state. Certainly a pilot project could be started in a state such as Illinois, with the assistance and support of the judicial system. While these tribunals would not necessarily decrease or prevent the malpractice causes of action, initially, at least the present backlog of cases would be unjammed. Plaintiffs and defendants would receive a speedy, efficient and fair disposition of their controversies and justice would be better served. Justice delayed is justice denied. Speedy action in malpractice cases would enable some plaintiffs to be relieved of the anxiety and whatever effect a delay might have on their overall medical condition. Perhaps in many cases, the prolongation of illness would be lessened. The trials would be speedier and the impaneling of a jury, the long parade of expert witnesses, and other demonstrative and dramatic elements of the usual trials could be eliminated for the most part. Time and expense would also be saved. There would be a greater emphasis and skill in the presentation of the facts.

Both physicians and attorneys alike should exert their combined efforts to reduce malpractice actions because such actions tend to undermine the public's confidence in the professions. The swift handling of legitimate malpractice problems, especially in the care of patients, will serve justice better and tend to separate the real cases, from the so called nuisance and unwarranted suits and claims.

Such a solution would be acceptable to the public and the medical profession. The busy physicians would be able to spend more time with patient care and the deliverance of medical care, rather than detracting them for long periods in preparing for potential law suits and settlement procedures.

*(Continued on page 198)*



## medical legal review

### *Keeping of records*

BY FRANK M. PFEIFER/ISMS COUNSEL

#### **Personal:**

All professional and business people should keep personal and financial records for at least six years and in the event of death, until after the estate has been closed. The keeping of adequate and important records cannot be overstressed for such procedure can resolve many problems and will certainly facilitate matters in the event of an investigation by any of the many taxing bodies and other governmental agencies which now have this power. In Illinois, in addition to the Federal Income Tax, one now has the Illinois Income Tax, the administration of which includes rather broad investigative powers. Some people still have the idea that it is good policy to destroy records for such a condition makes it difficult, if not impossible, for government to establish a tax deficiency. Nothing could be more incorrect, for the person having inadequate records immediately becomes suspect, is frequently subjected to a long time-consuming and expensive investigation and deficiencies can be established by the "net worth theory." Frequent consultation with your tax accountant will pay dividends.

#### **Medical:**

The statute of limitations in Illinois for personal injury cases, including malpractice, has always been two years after the alleged negligent act took place with the exception of a statute enacted in 1965 which provided that if a foreign substance was negligently permitted to remain within the body, and said foreign body caused harm or injury, the statute of limitations was extended so that a malpractice action could be commenced within two years after the discovery

of the condition, with a further overall limitation of ten years. It is always true that anyone under any legal disability has two years after the disability has been removed to institute the lawsuit.

In the recent case of *Dr. Menaker v. Michael Reese Hospital*, the Illinois Supreme Court did away with the two-year statute of limitations in those instances where the condition was not discovered until after the two-year period of time had elapsed and adopted the "discovery rule," which means that a malpractice case may be instituted at any time within two years after the alleged negligent act has been discovered or should have been discovered. This case does not specifically mention the ten-year limitation for foreign matter negligently left in the body but the Court would probably apply the discovery rule and hold that the lawsuit could be filed any time within two years after the discovery had been made or should have been made.

As a practical matter, the decision of our Supreme Court in the *Michael Reese Hospital* case means that there is no longer a statute of limitations insofar as malpractice cases are concerned. An action can now be brought at any time by a patient if he alleges that he discovered the alleged wrongful act within two years prior to filing the suit. It now becomes more important than ever not only to maintain adequate medical records, but to retain and protect them for they may be absolutely necessary in order to defend a case brought many years after the happening of the condition claimed to constitute malpractice. It therefore follows that to be absolutely safe, all physicians should retain the medical records during the lifetime of their patients. ◀



# Hypertension and ulcer

(Continued from page 142)

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## EKG

(Continued from page 143)

### Answers:

1. C & E. The electrocardiogram reveals atrial flutter with an atrial rate of 260 and 4:1 A-V block. A "saw-tooth" baseline of negative P waves is seen. The QRS complexes are normal. The ST-T segments are obscured by the "F" wave pattern.
2. B, C, D, and E. The patient's history suggests ischemic heart disease with angina pectoris complicated by episodes of atrial arrhythmia. These episodes may have permitted the development of Lt. atrial thrombi with subsequent cerebral embolus. The presence of 4:1 A-V block prior to treatment with any cardiac drug makes the presence of significant A-V block highly likely and makes treatment of atrial flutter by any means hazardous and to be attempted with caution. Cardioversion is the treatment of choice. Anticoagulation should be considered if cerebral hemorrhage can be excluded. Even if absent, encephalomalacia may worsen. Anti-arrhythmic agents (Quinidine) may have value in preventing recurrence of arrhythmia.

**Brief Summary of Prescribing Information—**9-9/22/69. For complete information consult Official Package Circular.

**Indications:** Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

**Contraindications:** Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

**Warnings:** Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

**Precautions:** Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

**Adverse Reactions:** Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

**Usual Dose:** 1 tablet b.i.d.

**Supplied:** Bottles of 60, 600, and 1000 scored 50 mg. tablets.

## Salutensin®

hydroflumethiazide, 50 mg./reserpine,  
0.125 mg. protoveratrine A, 0.2 mg.

**BRISTOL**

BRISTOL LABORATORIES  
Division of Bristol-Myers Company  
Syracuse, New York 13201



# The antihypertensive therapy that is easy to live with.\*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

**Easy-to-live-with control.** Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

\*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

**Easy-to-live with dosage.** Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

**Easy-to-live with cost of therapy.** The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

## Salutensin<sup>®</sup>

hydroflumethiazide, 50 mg./reserpine,  
0.125 mg. protoveratrine A, 0.2 mg.







## editorials

### The prostaglandins

Prostaglandins are a remarkable group of hormones with a wide clinical application. Thus far, 14 varieties have been discovered, each designated by its own appropriate letters. The hormone was found originally in human semen and given the name pros-ta-gland-in because large concentrations are found in the prostate gland. These naturally occurring substances are also present in all human tissues. More recently they have been synthesized.

These hormone-like chemicals are active via almost every route. When used vaginally, the prostaglandins are effective uterine stimulators without producing toxic effects. They induce spontaneous abortion in more than 90% of women during the first trimester of pregnancy. Prostaglandins induce labor in the last trimester by producing regular uterine contractions and progressive dilatation of the cervix.

They also stimulate menstruation and along this line may replace the "pill" and other contraceptive devices. Women need not do anything about contraception until they suspect they are pregnant. Vaginal suppositories containing prostaglandins are then given to induce menstruation, and if pregnancy exists, this terminates it. Abortion usually occurs within 15 hours. These

chemicals become in fact, a once-a-month anti-pregnancy product. Though in practice the drug is seldom needed more than three or four times a year, the plan is superior to taking a contraceptive pill virtually every day.

Social, ethical, and clinical consequences are bound to enter the picture, especially if prostaglandins are readily available and abortion on demand is the law of the land.

Prostaglandins also have remarkable cardiovascular effects. They lower blood pressure by reducing peripheral resistance. This stems from vasodilation of the arteries. The reduction in blood pressure is accompanied by an increase in cardiac rate and output, plus a three-fold increase in urinary output and loss of urinary sodium and potassium. The effect is rapid, and there is a possibility the products may be of value in pre-eclampsia and hypertensive crises.

When sprayed into the nose, the prostaglandins relieve nasal congestion, and since they dilate the respiratory passageways, may be useful in the treatment of asthma. The possibilities are endless, and this may be just the beginning. We understand that several hundred laboratories are conducting research on these unique compounds.

T. R. Van Dellen, M.D.

### Phototherapy for neonatal hyperbilirubinemia— More light on the subject

The use of phototherapy has been firmly established as a valuable procedure for treating hyperbilirubinemia of the newborn. Almost all hospitals in the country have installed bilirubin reduction fluorescent lamps. It is timely that Dr. Richard E. Behrman of the Department of Pediatrics, University of Illinois, College of Medicine, and Dr. David Hsia, chairman of the De-

partment of Pediatrics, Loyola Stritch School of Medicine, have formulated several guidelines for use of phototherapy. Pediatricians, generalists and obstetricians should find the following rules of great value.

The etiology of each case of neonatal jaundice should be established, if possible, before instituting phototherapy.

- Phototherapy should be used for infants in whom exchange transfusion is not indicated at the time but may become necessary if the rate of rise or the level of bilirubin rises above 10 mgm.

- Phototherapy should definitely be used following an initial exchange transfusion, to prevent subsequent exchange transfusions.

- Serial determinations of bilirubin should be obtained during and also after phototherapy, since rebound of the bilirubin can occur.

- Wave lengths between 300 and 600 mm. from 200 to 400 foot candles can be effective in reducing serum bilirubin in many premature infants.

- All infants' eyes should be shielded while undergoing phototherapy. Side effects include loose stools, rashes, priapism, changes in activity and delayed severe anemia in efforts with hemolytic disease.

- Informed consent should be obtained from the parents before initiating phototherapy.

Phototherapy has assumed an even greater importance because of the recent report of Odell, et al,<sup>2</sup> who have demonstrated that mental retardation can occur in full term infants and pre-

mature infants even when the level of bilirubin is below 20 mgm/%. Kernicterus has been reported in premature infants with levels below 20 mgm/%.<sup>3,4</sup>

It is important that the magic number of 20 mgm/% of bilirubin be discarded. The bilirubin of all infants should be carefully monitored and every effort be taken to keep the bilirubin as low as possible. Phototherapy is one way to achieve this goal.

H. Kravitz, M.D.

### References

1. Berman R. E. and Hsia D. Y. Y., "Summary of a Symposium on Phototherapy for Hyperbilirubinemia," *J. Ped.*, 75:718-726, 1969.
2. Odell G. B., Storey, G. N. and Rosenber, L. A., "Studies in Kernicterus III The Saturation of Serum Proteins with Bilirubin During Neonatal Life and Its Relationship to Brain Damage at Five Years," *J. Ped.*, 76:12-21, 1970.
3. Hodgman, J. E. and Schwartz, A., "Phototherapy and Hyperbilirubinemia of the Premature," *Am. J. Dis. Child.*, 119:473-477, 1970.
4. Stern, L., and Doray, B. H., "Hyperthermia Acidoses and Kernicterus in Small Premature Infants." Read before the 12th International Congress of Pediatrics, Mexico City, Dec. 2, 1968.

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## Ancient manuscript discloses Secrets of successful living

Someone whose name will never be known wrote a statement of philosophy in 1692, which was discovered centuries later in an old Maryland church. Still preserved, it is entitled **Desiderata**, Latin word for "anything desired as essential or needed." The author's counsel includes these admonitions:

Go placidly amid the noise and haste. As far as possible without surrender, be on good terms with all others. Speak your truth quietly and clearly. Listen to others, even the dull and ignorant; they too have their story.

Enjoy your achievements as well as your plans. Keep interested in your own career, however humble. Exercise caution in your business affairs, for the world is full of trickery. But let this not blind you to what virtue there is; many persons strive for high ideals, and everywhere life is full of heroism.

Be yourself. Especially do not feign affection. Neither be cynical about love, for in the face of all aridity and disenchantment it is as perennial as the grass.

Take kindly to counsel of years, gracefully surrendering the things of youth. Nurture strength of spirit to shield you in sudden misfortune. But do not stress yourself with imaginings. Many fears are born of fatigue and loneliness. Beyond a wholesome discipline, be gentle with yourself.

With all its sham, drudgery and broken dreams, it is still a beautiful world. Be careful. Strive to be happy.





# new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Products**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## Duplicate Single Products

**CYANTIN** Antiinfectives—Urinary R

**Manufacturer:** Lederle

**Nonproprietary name:** Nitrofurantoin

**Indications:** Pyelonephritis, pyelitis and cystitis

**Contraindications:** Anuria, oliguria, significant impairment of renal function, pregnancy at term and infancy under 3 months.

**Dosage:** Children: 5-7 mg./kg./24 hrs. in divided doses q.i.d. Adults: 50-100 mg. q.i.d.

**Supplied:** Tablets, 50 and 100 mg.

**CYCLOPAR** Antibiotics—B & M Spectrum R

**Manufacturer:** Parke-Davis

**Nonproprietary name:** Tetracycline HC1 (USP)

**Indications:** Treatment of infections caused by susceptible strains of gram-positive and gram-negative organisms.

**Contraindications:** Hypersensitivity to any of the tetracyclines.

**Dosage:** Children: 25-50 mg./kg./day in 4 divided doses. Adults: 1 to 2 grams daily in 4 divided doses.

**Supplied:** Capsules, 250 mg.

**LEMAZIDE** Diuretics—Benzothiazides R

**Manufacturer:** Lemmon

**Nonproprietary name:** Benzthiazide

**Indications:** Edema and hypertension

**Contraindications:** Hypersensitivity to sulfonamide derivatives, anuria, progressive renal and hepatic disease.

**Dosage:** Edema: Initially-50 to 200 mg. daily, maintenance-50 to 150 mg. daily

Hypertension: Initially 50 to 100 mg., maintenance-upward to 50 mg. t.i.d.

**Supplied:** Tablets, 25 and 50 mg.

**LITHIUM CARBONATE** Psychotropic R

**Manufacturer:** Philips Roxane

**Nonproprietary name:** Lithium carbonate

**Indications:** Control of manic episodes in manic depressive psychosis.

**Contraindications:** Significant cardiovascular or renal disease, or evidence of brain damage.

**Dosage:** Acute mania: 600 mg. t.i.d.; long term: 300 mg. t.i.d. Individualized according to serum levels and clinical response.

**Supplied:** Capsules, 300 mg.

**SERVISONE** Hormones—Corticoids R

**Manufacturer:** Lederle

**Nonproprietary name:** Prednisone

**Indications:** Suppressive action in a wide variety of allergic diseases. Management of a variety of collagen diseases, acute ocular posterior segment inflammatory diseases, certain lymphatic neoplastic diseases and in various diseases of unknown etiology.

**Contraindications:** Usual contraindications to corticosteroid therapy.

**Dosage:** Individualized. Average dosage, 20-80 mg./day for suppression.

**Supplied:** Tablets, 5 mg.

**THYROCRINE** Thyroid Preparation R

**Manufacturer:** Lemmon

**Nonproprietary name:** Thyroid (USP)

**Indications:** Replacement therapy in diminished or absent thyroid function.

**Contraindications:** Thyrotoxicosis and in cardiovascular conditions unless these are complicated by hypothyroidism.

**Dosage:** Individualized. Usual adult maintenance dose-1 to 3 grains daily. Cretinism-½ to 5 grains daily.

**Supplied:** Tablets 150 mg.

**VEETIDS** Penicillin & Deriv. R

**Manufacturer:** Squibb

**Nonproprietary name:** Penicillin Phenoxymethyl Potassium (USP)

**Indications:** Treatment of bacterial infections that respond to oral penicillin G therapy.

**Contraindications:** Syphilis, subacute bacterial endocarditis, meningitis and persons with hypersensitivity to penicillin.

**Dosage:** Infants: 50 mg./kg.

Others: Individualized

**Supplied:** Tablets, 250 and 500 mg., corresponding to 400,000 and 800,000 units phenoxymethyl penicillin respectively.

## Combination Products

**BREXIN** Cold Prep.—General R

**Manufacturer:** Savage

**Composition:** Pseudoephedrine HC1 60 mg.  
Methapyrilene HC1 30 mg.  
Glyceryl Guaiacolate 100 mg.

**Indications:** Relief of symptoms associated with allergies and infections of the upper respiratory tract.

**Contraindications:** Severe hypertension, hyperthyroidism, diabetes mellitus, organic heart disease, patients receiving MAO inhibitors or sensitivity to any of the ingredients.

**Dosage:** One capsule 3 or 4 times daily.

**Supplied:** Capsules

**OXOIDS** Ataraxic R

**Manufacturer:** Lemmon

**Composition:** Phenobarbital 20 mg.  
Ergotamine tartrate 0.3 mg.  
Belladonna extract 8 mg.

**Indications:** Nervous tension with accompanying exaggerated autonomic response.

**Contraindications:** Peripheral vasospastic and obliterative arterial disease, luetic arteritis, severe arteriosclerosis, coronary artery disease, thrombophlebitis, coronary heart disease, hypertension, impaired hepatic or renal function, bacterial sepsis, pregnancy especially in the third trimester, glaucoma and severe pruritis. Hypersensitivity to any component; porphyria.

**Dosage:** Four tablets daily, one upon arising; one with noon meal and two before retiring in evening.

**Supplied:** Tablets

**SINUTAB-II** Cold Prep.-General o-t-c

**Manufacturer:** Warner-Chilcott

**Composition:** Each tablet contains:

Acetaminophen 150 mg.

Phenacetin 150 mg.

Phenylpropanolamine HCl 25 mg.

**Indications:** Relief of symptoms associated with acute and chronic sinusitis, the common cold, and influenza.

**Contraindications:** None mentioned

**Dosage:** Children (6-12 years): One tablet every 4 hours.

Adults: Two tablets every 4 hours.

**Supplied:** Tablets

#### New Dosage Forms

**CHLOROMYCETIN** Eye Preparations R

**Manufacturer:** Parke-Davis

**Nonproprietary name:** Chloramphenicol (USP)

**Indications:** Superficial infections of the eye due to susceptible strains of *E.coli*, *Hemophilus influenzae*, *Staphylococcus aureus*, *Streptococcus hemolyticus* and *Moraxella lacunata*.

**Contraindications:** Hypersensitivity to the drug.

**Dosage:** Two drops in affected eye every 3 hrs. day and night for 48 hrs. Treatment should be continued for at least 48 hrs. after eye appears normal.

**Supplied:** Ophthalmic solution, 0.5%

**THEOKIN** Bronchodilator R

**Manufacturer:** Knoll

**Composition:** Theophylline calcium salicylate 448.5 mg.  
Potassium iodide 450.0 mg.

**Indications:** Symptomatic treatment of chronic obstructive pulmonary emphysema, bronchial asthma and chronic bronchitis.

**Dosage:** Children 6-12: ½ tablet/45 lbs. one or two times daily at intervals of not less than 6 hrs.  
Adults: One tablet two or three times daily at intervals of not less than 6 hrs. In severe attacks the usual dose may be increased by one-half.

**Supplied:** Tablets

**VALIUM** Ataraxics R

**Manufacturer:** Roche

**Nonproprietary name:** Diazepam (ND)

**Indications:** Symptomatic relief of tension and anxiety states. Adjunct for relief of skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, tetanus, epilepticus and severe recurrent convulsive seizures.

**Contraindications:** Infancy, hypersensitivity to the drug and acute narrow angle glaucoma.

**Dosage:** Individualized

**Supplied:** Ampuls, 2 cc.

Vials, 10 cc.

Disposable syringes, 2 cc. Each cc contains 5 mg.

**VEETIDS** Penicillin & Deriv. R

**Manufacturer:** Squibb

**Nonproprietary name:** Penicillin Phenoxymethyl Potassium (USP)

**Indications:** Treatment of bacterial infections that respond to oral penicillin G therapy

**Contraindications:** Syphilis, subacute bacterial endocarditis, meningitis and persons with hypersensitivity to penicillin.

**Dosage:** Infants: 50 mg./kg.

Others: Individualized

**Supplied:** Powder, each 5 cc. reconstituted solution provides 125 or 250 mg. phenoxymethyl penicillin corresponding to 200,000 and 400,000 units respectively.

## Rare disease on rise In United States

Brucellosis, a disease caused by various strains of brucella organisms, has not been a major health threat in this country since over 6,000 cases were reported in a single year about two decades ago.

At that time, the animal reservoir of the disease included mainly cattle, goats and swine. It spread to humans or from one animal to another through contaminated milk, or by containers with infected urine or feces. Now, according to the National Society for Medical Research in Washington, a new strain of the brucella organism which has only been known for five or six years is being found in the general population of dogs.

The new strain, called *Brucella Canis*, has

been brought to the attention of the Society by university research facilities which identified the organism in dogs received from local pounds and dealers. "This has revived our interest in the subject, and indications are that the disease may be more widespread than veterinary clinicians and physicians thought," said the group.

Human symptoms of the disease, commonly called undulant fever, are characterized by mild fever, loss of appetite and sore throat. They are flu-like and may also include muscular pains.

Symptoms to look for in infected male dogs are painful testes, fever, and loss of appetite. In female dogs, the symptoms are abortion, fever and loss of appetite.





# what goes on

## a guide to continuing education

### **Feb. 21-26—The American Academy of Forensic Sciences** *23rd Annual Program*

General sessions will explore the various relationships of the forensic sciences to the environment. Workshops, seminars and a special symposium.

Del Webb's Towne House, Phoenix, Arizona

### **Feb. 24-25—The Cleveland Clinic Educational Foundation**

*"A Review of Connective Tissue Diseases by Systems"*

#### Postgraduate Course

Musculoskeletal System, Allen H. MacKenzie, M.D.  
Peripheral Arteries, Arthur L. Scherbel, M.D.  
Central Nervous System, Thomas W. Wallace, M.D.  
Respiratory Tract, H. A. Van Ordstrand, M.D.  
Heart, Royston C. Lewis, M.D.  
Kidneys, Donald G. Vidt, M.D.  
Immunological Aspects of Connective Tissue Diseases, John D. Clough, M.D.  
Immunofluorescent Studies in Connective Tissue Diseases, S. D. Deodhar, M.D.  
Electron Microscopy in Connective Tissue Diseases, Abel Robertson, M.D.  
Corticosteroids, Constance S. White, M.D.  
Antimalarials and Nonsteroidal Antiinflammatory Agents, Allen H. MacKenzie, M.D.  
Cytotoxic Drugs, Arthur L. Scherbel, M.D.

### **Feb. 25-26—Southern Illinois Surgical Society**

*"Advances in Surgery"*

#### Surgical Seminar

George Crile, Jr., M.D., Senior Consultant in Surgery, Cleveland Clinic, "Current Approaches to the Treatment of Thyroid Carcinoma," "Perspectives in Breast Cancer"

John Siar, M.D., University of Pittsburgh, "Thyroid Disease in Children"

Richard Wetzel, M.D., University of Virginia, "Nuclear Medicine"

Antonio Boba, M.D., Wayne State University, "Anesthesia in the Hyperthyroid Patient"

Ken Smith, M.D., St. Louis University, "Hypophysectomy"

#1 Doctors Park Road, Mt. Vernon, Illinois

### **Feb. 26-Mar. 5—International Academy of Proctology**

*23rd Annual Congress and Teaching Seminar*

Scientific sessions with doctors from many parts of the world attending.

Mexico City, Mexico

### **March 1-2—New York University Medical Center**

*"Rehabilitation in Chronic Lung Diseases"*

The course will translate the theory and symbolic language of respiratory physiology into clear, clinical language of use to the practicing psychiatrist and physician.

NYU Institute of Rehabilitation Medicine, 400 E. 34th St., N.Y.

### **March 1-5—Society for Cryosurgery**

#### Annual meeting

The following specialties will be discussed: general surgery dermatology, gynecology, neurology, ophthalmology, otolaryngology and urology.

Diplomat Hotel and Country Club, Hollywood, Florida

### **March 2—Illinois State Psychiatric Institute** *"Self-Help—Similarities and Differences"*

#### New perspective seminars:

Carl Charnett, Director, Gateway Houses Foundation, Inc., Mrs. Mary Jane Maggio, Chicago Area Leader, Recovery, Inc., Mrs. Helen Scott, Chairman of Program and Education, Chicago Chapter, Parents Without Partners, Fred S., Gamblers Anonymous

ISPI Auditorium, 1601 W. Taylor St., Chicago

### March 3-4—The Cleveland Clinic Educational Foundation

#### *"Update 1971—Selected Topics in Nursing"*

Crisis in Nursing, Veronica Driscoll, R.N.  
Forensic Medicine-Nursing Liability, Carl E. Wasmuth, M.D.  
Controlling Hospital Infection-Role of Physician and Nurse, Martin C. McHenry, M.D., Eleanor Reilly, R.N.  
Latest Developments in the Management of Patients with Reconstructive Hip Surgery, Carl L. Nelson, M.D., Karen Krystowski, R.N.  
Current Practice in Treating the Gynecologic Patient, Lester A. Ballard Jr., M.D., Joann Kahtib, R.N.  
Communications, The Cornerstone of Human Relations, C. Gratton Kemp, Ph.D.  
Stress and Its Effects on Personality, Michael G. McKee, M.D., Janice Wasserman, R.N.  
What's Going on in Research?, Sharad D. Deohdar, M.D., Helen Kleinhanz, R.N.  
Current Management of the Cardiac Patient, Jacqueline Heed, R.N.  
Coronary Care, C. Charles Welch, M.D., Margaret Richmond, R.N.  
Cardiovascular Surgery, Rene G. Favaloro, M.D., Loretta Hallgren, R.N.  
Team Work in Resuscitation, John F. Viljoen, M.D., Virginia Meserko, R.N.

2020 E. 93rd St., Cleveland, Ohio

### March 4-6—American Society for Contemporary Ophthalmology

#### Annual Meeting

Highlights of the program center on the latest techniques in the treatment of cataract, glaucoma, retinal diseases and extraocular muscle imbalance. New concepts about the role of collagenase in the pathogenesis of corneal ulcer and revolutionary methods of treatment by inactivation of this enzyme. The increasing importance of interferon and other new agents in ocular pharmacology and therapeutics will be featured.

Diplomat Hotel and Country Club, Hollywood, Florida

### March 7-12—American College of Chest Physicians

#### Postgraduate course

Problems and approaches to the diagnosis and management of cardiopulmonary failure.

University of Miami School of Medicine, Miami, Florida

### March 10-11—The Cleveland Clinic Educational Foundation

#### *"Advances in Urology"*

#### Postgraduate course

Adrenal Causes of Hypertension, Ray W. Gifford, Jr., M.D.  
Renal Causes of Hypertension, Harriet P. Dustan, M.D.

Research Advances in the Field of Hypertension, F. Merlin Bumpus, Ph.D.  
Surgical Treatment of Adrenal Hypertension, Bruce H. Stewart, M.D.  
Surgical Treatment of Renal Hypertension, Joseph J. Kaufman, M.D.  
Immunologic Mechanisms in Cancer, George Crile, Jr., M.D.  
Diagnosis and Hormonal Therapy in Cancer of Prostate, David C. Utz, M.D.  
Radical Prostatectomy for Cancer of the Prostate, Lester Persky, M.D.  
Radiation Therapy in the Treatment of Cancer of the Prostate, Malcolm A. Bagshaw, M.D.  
The Management of Far Advanced Cancer of the Prostate, Ralph A. Straffon, M.D.  
Radiographic Diagnosis of Renal Tumors, Anthony F. Lalli, M.D.  
Management of Renal Cysts: Operate, Aspirate or Ignore?, Bruce H. Stewart, M.D.  
Renal Neoplasm-Current Surgical Management, William S. Kiser, M.D.  
Management of Low Grade, Low Stage Bladder Tumors, Joseph J. Kaufman, M.D.  
Radiation Therapy in the Management of Bladder Cancer, Malcolm A. Bagshaw, M.D.  
Conservative Management of Renal Failure, Donald G. Vidt, M.D.  
Dialysis: Home or Center, Satoru Nakamoto, M.D.  
Tissue Typing and Organ Transplantation, William E. Braun, M.D.  
Evaluation of a Transplanted Kidney with Radioactive Isotopes The B.F.D. Syndrome, Antonio R. Antunez, M.D.  
Kidney Salvage and Preservation, William S. Kiser, M.D.  
Current Status of Renal Transplantation, Ralph A. Straffon, M.D.

2020 E. 93rd St., Cleveland, Ohio

### March 15-17—New York University Medical Center

#### *"Remedial Techniques for Cognitive and Perceptual Difficulties in Brain-Damaged Persons"*

#### Postgraduate Course

Basic principles and techniques for the treatment of cognitive and perceptual problems of brain-damaged individuals, heretofore considered refractory impairments. The course is geared toward psychologists, physicians, occupational and speech therapists, and others.

Institute of Rehabilitation Medicine, 400 E. 34th St., N.Y.

### March 15-17—American College of Surgeons

#### Sectional meeting for Doctors and Nurses

Sessions in general surgery and nine surgical specialties: orthopedic surgery, gynecology-obstetrics, otorhinolaryngology, pediatric surgery, neurologic surgery, plastic surgery, ophthalmic surgery, thoracic surgery and proctology. Some 25 medical films and approximately 50 industrial exhibits of new equipment and accessories.

Fairmont, Roosevelt & Jung Hotels, New Orleans, La.

(save this for reference)



### March 15-26—The Abraham Lincoln School of Medicine

Postgraduate course in Laryngology and Bronchoesophagology

Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures

1855 W. Taylor St., Chicago

### March 17—Ames Company, Division of Miles Laboratories

Second International Symposium on Early Disease Detection

Sessions will include current concepts of early disease detection, the private practitioner, practical aspects of early disease detection, modular multiphasic screening and diagnostic program utilizing on-line computer.

University of Chicago, 1307 E. 60th St., Chicago

*(Save this for reference)*

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## ***Malnutrition linked to mental retardation***

Severe malnutrition of either the mother, the baby while in early stages of development, or both is a suspected cause of mental retardation, says the National Society for Medical Research.

They base their claim on the results of laboratory animal and human studies presented at a recent meeting of the Canadian Pediatric Society by Dr. Myron Winick, professor of pediatrics at Cornell University, which "... provide new and more conclusive evidence that severe pre- and post-natal malnutrition may inhibit division of cells in the growing brain," the Society reported.

Animal studies showed that if malnourishment is experienced during a period of fetal cell division, there is a permanent deficit in the number of brain cells as high as 15%. If an animal is severely malnourished both pre- and postnatally, there may be as high as a 60% reduction in the number of cells in the brain when brain cell division stops. The duration of the malnutrition as well as the severity and exact time is important in determining the total number of cells that will develop in the brain.

In humans, the same principles seem to apply. A study of severely malnourished Chilean children, both of those who are alive and those who have died, indicates similar results. The dead children's brain size had also been reduced due to an in-

hibition of cell division. Head size was also reported to be reduced proportionally. Those children who survived showed retardation of their motor and intellectual development.

Another recent report says that high incidences of low birth weights and deaths connected with low weight are found in the United States, which ranked thirteenth among 40 countries in 1966, in infant mortality. The birth weight of an infant is strongly associated with and conditioned by the weight gain of its mother as well as her pre-pregnancy weight and stature. Age of the mother and the number of children she has had are also important factors for determining the outcome of a pregnancy. Fetal loss and infant mortality are especially high among girls under 17 years of age, particularly those who have had repeated short-interval conceptions.

Surveys of human experiences during World War II and in lesser developed nations more recently have indicated that restriction of diet during pregnancy may unfavorably affect the growth and development of the fetus. In addition, laboratory experiments on dogs, sheep and other animals show a marked reduction in the size of the offspring when the mother is maintained on an inadequate diet.

Environmental factors which may relate to malnutrition seem to be especially prevalent in lower socioeconomic levels of our society.

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\*based on actual drug store survey of prescribed dosages





## socio-economic news

a service of the division of health care delivery

By JOSEPH J. LOTHARIUS

### IDPA agrees to ISMS request

The Illinois Department of Public Aid will no longer implicate ISMS' 1966 fee survey in the Department's letters to physicians refusing fee increases, according to Director Harold O. Swank. ISMS Board Chairman, Dr. Willard C. Scrivner, voiced the Society's objection to any mention of the 4-year old survey in IDPA letters to physicians who had requested review of their fee profiles.

In a letter to Dr. Scrivner, Mr. Swank said future Department correspondence of this type to physicians would contain the following explanation: *"The Department of Public Aid pays for physician's services at his usual and customary fee, if reasonable. The concept of reasonableness is based on profile information gathered by participating physicians in geographical areas of the State. The reasonableness of a charge is determined by the prevailing fee of the total physicians in your geographical area. The amount of money paid on your original billing is the maximum that can be paid under this concept."*

\*\*\*\*\*

### Illinois MDs paid 84.2% Of their medicaid billings . . . IDPA says

Illinois physicians were paid \$16 million out of the \$19 million they billed IDPA during the first nine months of 1970, according to Director Harold O. Swank. In his letter to Dr. Willard C. Scrivner (mentioned above), Mr. Swank said these figures reflect an 84.2% ratio of payment to charges of the 6,600 physicians throughout the state participating in the Medicaid program. "The ratio of payment to charges is almost identical between the Cook County and Downstate areas, with the area outside of Cook County having a slightly higher ratio," Mr. Swank noted. He said as late as July 1, 1970, on a review of billing charges by physicians, it was shown the Department maintained statewide maximums accommodating at least the 70th percentile.

"A review of the top ten procedure codes as they relate to total expenditures indicate that all are at or above this figure and in three instances the 70th and 80th percentile are identical so that the maximum allowable charge for these procedure codes will accommodate at least 80% of the practitioners billing for this service." Mr. Swank's letter



pointed out HEW regulations effective July 1, 1969 prohibited states from paying fees in excess of amounts that would accommodate the 75th percentile of physicians within the state. He said this regulation was imposed "with the full knowledge and publication by HEW that Title XVIII (Medicare) payments were being made by the fiscal intermediary at approximately the 83rd percentile."

\*\*\*\*\*

## **HEW predicts \$156 billion For medical care by '80**

Total expenditures for medical care are expected to almost double by 1975—from \$57 billion in 1968, to \$111 billion, according to HEW predictions. By 1980, expenditures should reach \$156 billion. In per capita terms, the 1980 figures will be approximately \$670 per year compared with \$280 in 1968. During this period, HEW expects hospital care to almost quadruple—from \$21 billion in 1968 to \$76 billion in 1980. *Physicians' services are expected to rise two and one-half times the 1968 total—from \$12 billion to \$29 billion.*

\*\*\*\*\*

## **Medicaid in California Only for emergencies**

Only emergency cases are being accepted under new Medi-Cal (Medicaid) regulations in California due to an anticipated fiscal deficit of \$200 million in the program. The drastic cuts, announced by state officials, including a 10% reduction of fees paid to physicians and all other providers (except hospitals inpatient services), became effective in mid-December. California Governor Ronald Reagan said "blaming doctors for this crisis would be unfounded and contrary to the facts. Doctors and others generally have had to absorb the effects of inflation. . . . The truth is the taxpayers owe most of them a debt of gratitude."

California Medical Association's President, Dr. Ralph W. Burnett said "it is absolutely unfair to expect the physicians of California to underwrite Medi-Cal even further, by accepting another cut in fees that were substandard when Medi-Cal began four years ago. Optimum care for Medi-Cal patients simply is no longer possible under these new regulations that generally restrict care to emergencies."

---

### **Don't put time out of mind**

"There's a time for all things," William Shakespeare wrote, and some modern scientists have followed up by prescribing the best time of day for almost everything.

For example: **What's the best time to get up in the morning?** As soon as you wake, so you won't get tired all over again, thinking of the chores that face you.

**What's the best time to make important decisions?** Midday, when you have the clearest perspective.

**To blow your top?** Thirty minutes before meals.

**To learn?** Just before bedtime: we remember four times as much if study precedes a long rest.

**To convince others?** During a meal, most salesmen agree, because the pleasure of eating lowers resistance to persuasion.





## public affairs

a service of the division of legislation and public affairs

### ***ISMS Washington Round-up set for April 25-27***

The annual *Washington Round-up of the Illinois State Medical Society* will be held in conjunction with the annual meeting of the Chamber of Commerce of the United States.

The Round-Up, this year, will be held during cherry blossom time, April 25-27. Plans are now underway to add an additional day to the Chamber of Commerce meeting which will be devoted exclusively to medical developments at the national level.

This has become one of the most popular, informative and useful events and is offered to every member of the Illinois State Medical Society. Spouses are urged to participate.

Although the details of the program are still being developed, you are urged to mark your calendar now and watch your mail and the ISMS publications for further information.

### ***IMPAC has an "impact"***

November 3, election results demonstrate IMPAC has an overall .860 batting average in its support of candidates seeking Congressional, state senate and representative seats.

A more thorough analysis of election statistics demonstrates IMPAC made an even more impressive showing in the "tight" state representative and senate races.

Any district in which the election returns fall within a 55-45% vote split is considered a marginal or "swing district" by political organizations. These are the areas organizations pour money, manpower and additional resources into. There were 14 senate and 19 representative districts which fell into this category November 3.

In the 14 senate races IMPAC funds bolstered the campaigns of 85% (12) of the winners. In one race, IMPAC funds went to both the Republican and Democrat candidates (both were favorable to medicine) with the Democrat winning. In two races (not supported by IMPAC) both Democrats won election.

The tightest race was in the 41st district, (Will

and Grundy counties) in which incumbent Senator Meade Baltz (R-Joliet), with IMPAC support, won with 50.1% of the vote.

Cumulative voting in the representative races resulted in psychedelic-like election returns, which IMPAC had a hand in creating.

Eighty-two per cent (47) of the successful candidates in the 19 marginal house districts had IMPAC support. Of the 10 winning candidates not supported by IMPAC, eight are Democrats and two are Republicans.

In three house districts (4th, 41st, 53rd) the two Republican candidates received fewer votes than the two Democrat candidates, but managed to win election. A wide margin separated the two Democrat candidates, allowing both Republican candidates to squeak into office. In all three cases IMPAC supported the two GOP candidates, and in two of the three districts IMPAC supported the successful Democrat candidate.

In the 41st District, IMPAC supported neither Democrat candidate. House Speaker W. Robert

Blair (R-Park Forest) won reelection in this district along with incumbent John Houlihan (D-Park Forest). Freshman George M. O'Brien (R-Joliet) was Blair's running mate.

In the marginal House districts there were six instances in which the fourth (and losing) man in the race came within five per cent of the number three (and winning) candidate. In five cases IMPAC supported the winning candidate. In the sixth case IMPAC supported the losing

candidate, who came within 2.5% of winning the seat.

Eight Democrat and two Republican candidates won election from these marginal districts without IMPAC support as opposed to 16 Democrats and 31 Republicans who won with IMPAC support.

These election results definitely indicate IMPAC can be an effective political arm if physicians care enough to participate.

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## ***Chromosomal abnormalities may warn of leukemia***

The possibility that chromosomal abnormalities in bone marrow are an early warning of leukemia is the object of a long-term study in The Pritzker School of Medicine of The University of Chicago.

Dr. Janet Rowley, associate professor of medicine in The Pritzker School of Medicine, notes that the possibility is an unproven assumption—one that has been subjected to close scrutiny at Chicago during the past six years.

The significance of establishing a relationship, if it exists, is obvious. If chromosomal abnormality is an early signal, treatment could be instituted before the disease became clinically apparent—before the abnormal cell line became dominant.

Dr. Rowley's own study began in 1964, but physicians were pondering the significance of the "pre-leukemic" pattern as early as 1950. They also were working to devise ways in which to make definite diagnosis of the disease at an earlier stage.

In March 1950, Dr. Matthew Block of the University of Colorado and Dr. Leon O. Jacobson of The University of Chicago, writing in the *Journal of the American Medical Association*, reported a technique of spleen biopsy to distinguish between types of leukemia and other diseases which attack the blood-forming organs.

This step in differentiating between leukemia and diseases which imitate it laid the groundwork for still other investigations. The technique of examining bone marrow for chromosomal abnormalities was introduced in 1959-60. Physicians then wondered if the abnormality was present first

or was secondary to the disease process. A few hypothesized that the irregularity might make a person more susceptible to diseases such as leukemia—and that perhaps it was an inherited trait.

Dr. Rowley said, "In 1964-65 I thought if we found patients with chromosomal abnormalities, leukemia would develop and the patients would die within a period of months. Now we know abnormalities can be present for a long time with no evidence of leukemia."

The chromosomal abnormality usually consists of too many, too few, or broken chromosomes. In the bone marrow of one woman, for example, there were two, too many chromosomes in about 20% of the cells studied. A highly magnified photomicrograph of chromosomes shows that some look roughly like an X (others have a V-shaped appearance). The photomicrographs of some patients show a portion of the X broken off or some irregularity of formation. Dr. Rowley thinks that about 50% of leukemic patients have some such pattern and that more probably have abnormalities too small to be detected.

"We can only identify a portion of the abnormalities," she said, pointing out that in hemophilia (a sex-linked blood disorder related to clotting) the chromosomes appear normal.

"We know, however," she continued, "where the difference is; but the tools of today are too gross to permit us to see it."

In her ongoing study, Dr. Rowley has seen more than 100 persons who fall into the general pre-leukemic pattern. About  
(Continued on page 185)

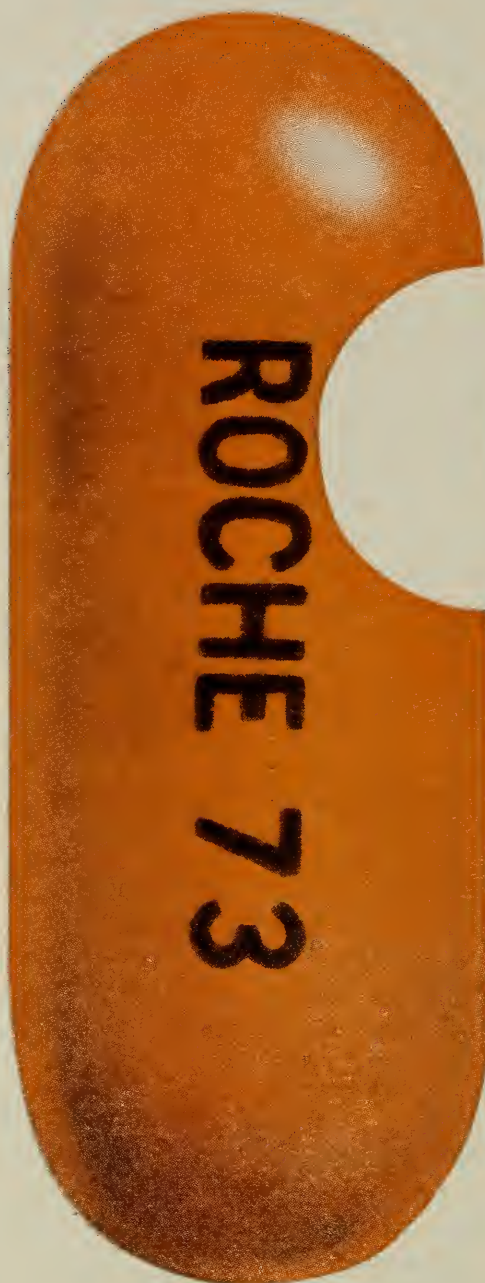


# the incomplete B-complex

SPECIFICALLY FOR LEVODOPA PATIENTS—NUTRITIONAL SUPPORT WITHOUT PYRIDOXINE

Larobec provides: B-complex vitamins, of particular importance to the patient who is on levodopa therapy and is deficient in water-soluble vitamins.

Larobec provides: Ascorbic acid, useful in assisting tissue repair in the debilitated patient.



Larobec does *not* provide: Pyridoxine (vitamin B<sub>6</sub>)—which reportedly reverses the antiparkinson effects of levodopa therapy.<sup>1,2</sup>

## Larobec<sup>T.M.</sup> Tablets

A high-potency nutritional supplement specific to the needs of patients with Parkinson's disease and syndrome on levodopa therapy—that describes new Larobec<sup>T.M.</sup> from Roche. Larobec provides the major B vitamins plus vitamin C—but does not provide pyridoxine. Thus, with its specially tailored formula, Larobec assures the patient important nutritional support without minimizing any of the benefits of levodopa therapy.

1. Duvoisin, R. C.; Yahr, M.D., and Coté, L. D.: *Trans. Amer. Neurol. Assoc.*, 94:81, 1969.  
2. Cotzias, G. C.: *J.A.M.A.*, 210:1255, 1969.

#### Complete Prescribing Information:

Each Larobec tablet contains:

Thiamine mononitrate (vitamin B <sub>1</sub> )	15 mg
Riboflavin (vitamin B <sub>2</sub> )	15 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin (vitamin B <sub>12</sub> )	5 mcg
Folic acid	0.5 mg
Ascorbic acid (vitamin C)	500 mg

**Description:** For prophylactic or therapeutic nutritional supplementation concomitant with levodopa therapy in patients with Parkinson's disease and syndrome, Larobec provides high potency dosages of the major B-complex vitamins, without pyridoxine (vitamin B<sub>6</sub>) which has been reported<sup>1,2</sup> to reduce the clinical benefits of levodopa therapy. B-complex vitamins are essential in the anabolism of carbohydrate and protein and in hematopoiesis. Larobec also contains therapeutic quantities of ascorbic acid, a substance involved in intracellular reactions such as tissue repair and collagen formation.

**Indications:** Larobec is indicated for supportive nutritional supplementation when a water-soluble vitamin formula (without pyridoxine) is required prophylactically or therapeutically in patients under treatment with levodopa.

**Warning:** Administration of vitamin B<sub>6</sub> may be required if signs of pyridoxine deficiency develop. Larobec is not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B<sub>12</sub>.

**Dosage and Administration:** One or two tablets daily, as indicated by clinical need.

**How Supplied:** Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.

#### References:

1. Duvoisin, R. C., et al.: *Trans. Amer. Neurol. Assoc.*, 94: 81, 1969.
2. Cotzias, G. C.: *J.A.M.A.*, 210:1255, 1969.

high-potency  
nutritional support for  
the levodopa patient

# Larobec<sup>T.M.</sup>



Roche Laboratories  
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## Chromosomal . . .

(Continued from page 185)

10% displayed chromosomal abnormalities in bone marrow cells, but only one later developed leukemia. Since 1964, approximately 30 of the total group of patients have died, but only three of acute leukemia. The age of the patients ranges from 18 to 80 years. The number of males and females is roughly equal, with chromosomal abnormalities found more frequently in males.

Her control group consists of 80 patients with hematologic disorders of the blood secondary to some other disease process. In these patients, the bone marrow chromosomes are normal.

Dr. Rowley pointed out that at present only a few scientists around the country are studying the significance of chromosomal abnormalities in pre-leukemic patients. She also thinks it likely that no other laboratory has a follow-up study in progress as large or covering as long a period of time as the study at Chicago.

One patient cited by Dr. Rowley was studied for two-and-a-half years prior to death. He showed abnormal bleeding caused by too few platelets (the cell-like body in the blood which controls clotting). A chromosomal abnormality was noted in 60% of the marrow cells. When his spleen was removed, the same chromosomal abnormality was apparent in about 20% of the cells. Approximately one month before his death, the abnormal cell line became progressively more dominant and was evident in 95% of the marrow cells; at this time he clearly had acute myelocytic leukemia.

Other patients studied have been followed for as long as five years, and some with quite low platelet counts still are alive. Since some have died from other causes, one unresolved question is whether they would have developed leukemia had they lived long enough.

"Kidney Function Tests" is a 16 mm, 43 minute film dealing with the origin and meaning of renal function tests, including the blood urea nitrogen and the creatinine clearance tests. Contact: National Medical Audiovisual Center (Annex) Station K, Atlanta, Ga. 30324.



# *Schedule of clinics for handicapped*

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will hold twenty-three general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions and rheumatic fever; and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 2 Alton—Alton Memorial Hospital  
March 2 Carrollton—Boyd Memorial Hospital  
March 3 Carmi—Carmi Township Hospital  
March 4 Sterling—Community General Hospital  
March 4 Springfield—St. John's Hospital  
March 4 Macomb—McDonough District Hospital  
March 4 Effingham—St. Anthony Memorial Hospital  
March 4 Lake County—Cardiac—Victory Memorial Hospital  
March 5 Chicago Heights—Cardiac—St. James Hospital  
March 9 Peoria—St. Francis Children's Hospital  
March 10 Joliet—St. Joseph's Hospital  
March 10 Champaign-Urbana—McKinley Hospital  
March 16 East St. Louis—Christian Welfare Hospital  
March 16 Rock Island Area General—Moline Public Hospital  
March 17 Jacksonville—Norris Hospital

March 17 Evergreen Park—Little Company of Mary Hospital  
March 18 DuQuoin—Marshall-Browning Hospital  
March 18 Decatur—Decatur Memorial Hospital  
March 18 Elmhurst—Cardiac—Memorial Hospital of DuPage County  
March 23 Belleville—St. Elizabeth's Hospital  
March 23 Peoria—St. Francis Children's Hospital  
March 24 Springfield—Pediatric Neurological — Diocesan Center  
March 24 Centralia—St. Mary's Hospital  
March 24 Rockford—St. Anthony Hospital  
March 24 Elgin—Sherman Hospital  
March 26 Chicago Heights—Cardiac—St. James Hospital  
March 30 East St. Louis—Christian Welfare Hospital  
March 31 Metropolis—Massac Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions, or those suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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## **Monthly Guaranteed Handouts Proposed**

"More than 70% of the cost of the Nixon welfare proposal would go for cash payments. Here is where the emphasis of the bill really lies. The bill ultimately establishes the basis of a guaranteed annual income through a negative tax formula. It would permanently consign more than 10% of our national population to welfare handouts."—Rep. Al Ullman (D.-Ore.)

# *Professional ideals: A report of the Judicial Council*

*Adopted by the House of Delegates,  
December 1, 1970*

Recently many letters have been received by the Judicial Council complaining of an apparent preoccupation by an increasing number of physicians with the financial aspects of their medical practice.

The Judicial Council reaffirms that the laborer is worthy of his hire and the physician is entitled to reasonable compensation for the service he performs. At the same time, the Council must point out that the "prime object of the medical profession is to serve humanity; reward or financial gain is a subordinate consideration."

In 1934, the House of Delegates said "one of the strongest holds of the profession on public approbation and support has been the age old professional ideal of medical service to all, whether able to pay or not." The Council believes it would be helpful if the House were to reaffirm that policy at this meeting.

Some physicians seem to believe that the practices of business enterprises should be utilized by physicians in order to "encourage prompt attention to medical accounts." They ask, "Why shouldn't we be paid as soon as the dry goods store, the grocer, or the TV service man?"

If the profession was to cast aside its ideals and traditions, and adopt the practices of business, trade or industry in dealing with patients, then the profession would also be casting aside the perquisites that have been accorded it. The increase of collections by adding 1½% interest

per month to a bill of an honest patient embarrassed because of inflationary trends, or the bill of some retired person living on a small pension is, in the opinion of the Judicial Council, not justifiable. It simply is not worth it from any point of view. The imposition of a penalty on the bill of a "deadbeat" is not likely to cause him suddenly to change; the chances are he will become even less likely to pay.

A physician who demands a satisfactory credit report on an individual before accepting that individual as a patient is demonstrating that to him financial compensation is the prime object and reward of his profession.

A physician who publicly refuses to see a patient, who had an appointment, because the patient's balance of account was "too high" is demonstrating that he respects neither himself nor his profession.

The Judicial Council therefore recommends that the House of Delegates reaffirm that the prime object of the medical profession is to render service to humanity; financial gain is a subordinate consideration.

The Council recommends that the House call this reaffirmation of policy to the attention of constituent and component medical societies, asking them to urge all physicians to adhere faithfully to the professional ideals, traditions and goals of American medicine.





# practice management

BY ROBERT P. REVENAUGH/PROFESSIONAL BUSINESS MANAGEMENT, INC.

## *“The appointment system-- Tool or terror!”*

Most practices follow an appointment system for office visits for the convenience of both patient and doctor. If patient waiting time is reduced, the doctor is not prodded by the pressure of a “standing room only” crowd; but, no system is better than the people who make it work. Primarily the receptionist, but the doctor as well, share the responsibility. I have been in offices where thirty collective hours of patients’ time have been exhausted in an afternoon waiting for a doctor who arrived one hour late at the office. We have a conscientious client whose heart attack was attributable to an inexperienced receptionist jamming the appointment book!

After many years of business consulting for the medical profession, I have several observations concerning appointment systems:

1. After a lengthy wait a patient is not in the best frame of mind to consult with the doctor; therefore medical treatment can be adversely affected.
2. The longer the patient waits in the reception room, the more time he wants in the examination room to leisurely describe his symptoms. Some symptoms are real—and some were imagined as the patient waited.
3. The number of phone calls received by a doctor is directly proportional to the time a patient anticipates waiting in his reception room. Patients prefer calling to waiting.
4. Busy patients will not tolerate undue waiting. Over a period of years the patients remaining will consist only of people who have free time.

5. A well-run appointment system will reduce the cost of waiting room space.

How does a good appointment system operate? It first starts with a proper appointment book. An amazing number of office practices are run by appointment books that doctors have received free through the mail. Half of the page is unused because the printed hours do not correspond to the doctor’s actual office hours. The time intervals may not be appropriate, no space is allotted for recording work to be done, and there is no room for new patients’ phone numbers. Most consultants suggest that for five or six dollars the doctor have his own individually designed loose-leaf appointment schedule printed, which would provide ample space to let the receptionist write legibly. At the beginning of office hours, the schedule is either typed up or photocopied. One copy is given to the doctor and another to the nurse. The notation of work to be done allows the nurse to properly place and prepare patients. The doctor’s copy allows him to instantly evaluate the day’s progress and pace himself accordingly.

The appointment system controls the office work flow. A good receptionist knows the work to be done for patients and how long it takes the doctor to carry out various procedures, thus she can schedule accordingly. A wise doctor knows that his late arrival at the office will mangle the best prepared schedule. An experienced aide will strategically place buffer or blank spots in the appointment schedule to accommo-

date the inevitable emergencies or allow the doctor to catch up. A considerate doctor will not just tell people to "come into the office," but will refer them to the receptionist to schedule. If a doctor calls in to say that he will be late, a smart receptionist will review the day's schedule with the thought of reappointing less urgent visits to another day. When another appointment is needed for a patient the doctor has just finished examining, the doctor should indicate to the receptionist just how much time will be needed for the reappointment. A courteous re-

ceptionist will truthfully tell arriving patients how long they must wait before seeing the doctor.

In describing the appointment system to a new receptionist I like to describe it as being like the operation of a color television; by fine tuning one receives the desired result. The receptionist turns the knobs and pushes the buttons, thereby affecting the entire work flow in the office. She can make the appointment system a tool for a smooth running office or a terror for the doctor and the entire staff. ◀

---

## Official Call For Scientific Exhibits

1971 ANNUAL MEETING OF ISMS  
Arlington Park Towers — May 17-18-19

The Committee on Scientific Assembly invites members of the Illinois State Medical Society to submit applications for scientific exhibits at the Society's 1971 annual meeting May 17-19 at the Arlington Park Towers, Arlington Heights, Illinois.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the meeting are requested to file an application before March 15, 1971, giving the basic equipment which will be needed. Awards are given to exhibits of exceptional value. Assignments are made as exhibits approved by the Committee on Scientific Assembly.

There is no fee charged for scientific exhibits, but the exhibitor must pay the cost of installing the exhibit, of tables and chairs that may be rented, for alterations or all other construction. Single exhibit space is 8x10 feet.

Those interested in providing an exhibit are requested to file an application and a full description of the exhibit.

DEADLINE FOR APPLICATIONS: March 15, 1971.

Contact: Director of Scientific Exhibits  
Illinois State Medical Society  
360 North Michigan Avenue  
Chicago, Illinois 60601

Director of Scientific Exhibits  
Illinois State Medical Society  
360 North Michigan Avenue  
Chicago, Illinois 60601

Please send Scientific Exhibit Application Forms to:

NAME .....

ADDRESS .....

CITY & ZIP CODE .....

(Please Print)



## *Orthopaedic assistant now on the health scene*

A new breed of health professional—the orthopaedic assistant—is on the scene.

He is to become an integral part of the orthopaedic surgical team and assist the orthopaedic surgeon to maintain high standards in delivery of services to the public.

Dr. F. Richard Schneider of Daly City, California, and Dr. John J. Niebauer of San Francisco, described a pilot program for the training of the orthopaedic assistant.

He is trained to apply a variety of plaster casts and instruct patients in their routine care. He can manage equipment and supplies in both the traction and cast areas. In the operating room he is able to act as a surgical technician, understand the sharpening of orthopaedic osteotomes and gouges, and the complexity of various screw drivers and drills. In the emergency room he understands surgical technique and is able to set up for minor surgical procedures. He can apply simple braces and prosthetics in both the hospital and office and carry out minor adjustments and repairs. He can instruct and help patients in crutch walking on hospital floors and encourage them in exercises.

"These various functions require more than a smattering of on-the-job training," Dr. Schneider said in a presentation at the Annual Meeting of the American Academy of Orthopaedic Surgeons.

The assistant must have a general education core of courses to broaden his back-

ground and develop both personal and social maturity, a health careers core to provide orientation to patient care, and an orthopaedic assisting core of studies.

The pilot program conducted in San Francisco consists of a two-year curriculum involving City College and U. S. Public Health Service Hospital instruction.

In April, 1968, the executive committee of the American Academy of Orthopaedic Surgeons approved the orthopaedic assistant as the new member of the allied health team and recommended that he receive certification for service under the general guidance of the orthopaedic surgeon. On December 2, 1969, the House of Delegates of the American Medical Association approved the plan leading to accrediting training programs for the orthopaedic assistant.

"The orthopaedic assistant has much going for him; namely, that there is a definite need, and the American Academy of Orthopaedic Surgeons has shown the foresight to participate in and back this new allied health professional. The orthopaedic residents in training now, and in the future, will and should grow up with these assistants so that the utmost cooperation might be obtained."

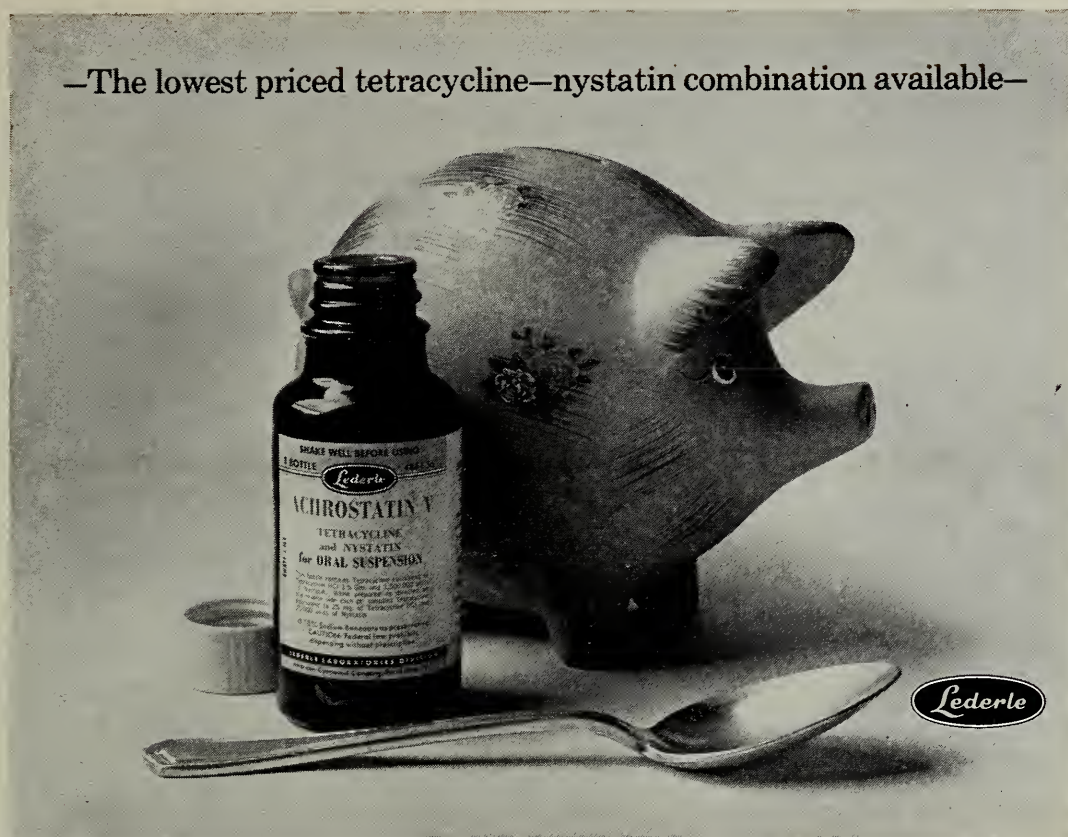
In the years ahead Dr. Schneider envisions the assistant participating in history-taking, making his own rounds, applying casts of greater complexity, and assisting in orthopaedic surgical cases.

---

### **Where the Action Is**

"The National Chamber is an instrument of change—not the status quo. At the local level, there's no more natural organization to serve as the community's instrument for change and action than the local chamber. Chambers of commerce promote change, rather than resist it. They instigate, lead and foster change."—Arch N. Booth, executive vice president, Chamber of Commerce of the United States.

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## **Diabetic pregnancies researched**

It is a well-known fact that babies of diabetic women are at much higher risk of death or disabling birth defects than are the infants of nondiabetic mothers. However, the reasons for the hazards of diabetic pregnancies are far from clear.

Dr. W. Ann Reynolds, associate professor of anatomy in the University of Illinois College of Medicine, Chicago, is seeking the reasons by studying insulin effects on fetal development in diabetic and nondiabetic monkeys. Dr. Reynolds' study is being conducted under a \$17,445 research grant from the National Foundation-March of Dimes. Dr. Ronald A. Chez of Magee-Women's Hospital, Pittsburgh, Pennsylvania will collaborate in conducting the research.

Dr. Reynolds will study pregnant rhesus monkeys, who are normal as well as those made diabetic by a chemical injection, to learn if the fetus overproduces insulin in response to the sugar level of maternal blood which reaches it, or whether too much of the mother's insulin reaches the baby across the placenta.

Fetal sugar and insulin levels will be compared at various stages of pregnancy in four groups of monkeys: normal, untreated diabetic, diabetic treated with insulin and normal monkeys given insulin injections.

The fetal pancreas and placentas from each group will be examined microscopically and biochemically for clues regarding basic differences.

---

## **Community health effort—means to an end**

This doesn't mean that a large university, like Yale, should immediately accept the full responsibility for all the health care of the city it inhabits, but it does mean that representatives of the university must sit down with members of the community—with sleeves rolled up, so to speak—and join in the CHP effort: give guidance, hear out the problems as they exist and are presented, and put some of their best scholars to work on devising and, at times, actually carrying out more effective means of meeting community needs.

None of this is intended to be an assault on Yale, I hasten to add; these recommendations apply nationally. As a matter of fact, Yale University is more deeply involved through its department of a prepaid group-practice plan for the New Haven area. (Similar plans are being developed by Harvard and Johns Hopkins in their areas.)

It seems to me that, sooner or later, we shall all have to recognize that the crucial point about Comprehensive Health Planning, on which will depend the verdict rendered by our great-grandchildren, is whether or not it actually solved unmet health needs, as it sought to meet the immediate wishes of citizen groups in the search for political relevance. Health is all too often used as a means to some other end, but the test of success to physicians must eventually be "health as an end unto itself." (George James.: *The Comprehensive Health Planning Program. Medical Opinion & Review* (Sept.) 1970, pages 44-45, 49.)

## Rx Product Index

<i>Achrostatin</i> .....	193
Lederle Laboratories	
<i>Alpha Keri</i> .....	195
Westwood Pharmaceuticals, Inc.	
<i>Dicarbosil</i> .....	198
Arch Laboratories	
<i>Donnagel/Robitussin</i> .....	119-121
A. H. Robins Co., Inc.	
<i>Dyazide</i> .....	3rd Cover
Smith Kline & French Laboratories	
<i>Empirin Compound w/Codeine</i> .....	110
Burroughs Wellcome & Co.	
<i>Elavil</i> .....	122-123
Merck Sharp & Dohme	
<i>Fleet Enema</i> .....	129
C. B. Fleet Co., Inc.	
<i>Kinesed</i> .....	106-107
Stuart Pharmaceutical Div., Atlas Chemical Industries, Inc.	
<i>Theragran</i> .....	104
E. R. Squibb & Sons, Inc.	
<i>Hygroton</i> .....	177
Geigy Pharmaceutical Corp.	
<i>Ilosone</i> .....	130
Eli Lilly and Company	
<i>Larobec</i> .....	184-185
<i>Librium</i> .....	108-109
<i>Noludar</i> .....	199
<i>Valium</i> .....	Back Cover
Roche Laboratories Div., Hoffmann-LaRoche, Inc.	
<i>Lomotil</i> .....	2nd Cover, 1
G. D. Searle & Co.	
<i>Salutensin</i> .....	168-169
<i>Tetrex b.i.d. Caps</i> .....	124-125
Bristol Laboratories	
<i>Surfak</i> .....	179
Hoechst Pharmaceutical Co.	
<i>Synirin</i> .....	127
Wm. Poythress & Co., Inc.	
<i>Orenzyme/AVC</i> .....	113, 114
<i>Tepanil/Quinamm</i> .....	187, 188
National Drug Company	
<i>Vasodilan</i> .....	116-117
Mead Johnson Laboratories	



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## ***Ethyl and grain alcohol counteract***

### ***Effects of methyl and wood alcohol***

Ethyl, or grain, alcohol can be used to prevent the blindness, brain damage, and death that can result from drinking methyl, or wood, alcohol, according to a physician at The University of Chicago.

Dr. Albert M. Potts, professor of surgery, and his colleagues in The University of Chicago's Division of the Biological Sciences and The Pritzker School of Medicine, have been studying the effects of methyl, or wood, alcohol on the body.

Wood alcohol acts on the body in three distinct ways, according to Dr. Potts.

"Methyl alcohol, in high concentrations, acts as an organic solvent—the same as gasoline or kerosene—to destroy tissues and cause death," he said. "However, this is not common, because of the high level of concentration necessary to damage the body."

The blindness, brain damage, and death usually associated with the drinking of wood alcohol is not caused by the alcohol itself but the chemicals produced when the alcohol is oxidized by the body.

"Acidosis, or an abnormally high level of acid in the blood, is one factor in the permanent body damage or death that can result from drinking wood alcohol," said Dr. Potts. "The enzymes in the body oxidize the alcohol and produce acids. While these acids alone are not enough to cause injury, the oxidation process stimulates the liver to produce additional acids and the blood level of acid reaches dangerous levels," he stated.

Other chemicals that result from the oxidation of methyl alcohol affect the nervous system—especially the brain and eyes.

"Formaldehyde and perhaps other oxidation products destroy the ganglion cell of the retina (the back part of the eye upon which visual images are formed). The

death of the ganglion cell in turn destroys the optic nerve," Dr. Potts said.

Formaldehyde also attacks catecholamines, a group of chemicals found primarily in the sympathetic nervous system that transmit nerve function from one nerve cell to another. The effect of alcohol-induced lack of catecholamines depends upon which area of the nervous system is involved.

"In one area of the brain, formaldehyde attacks the amine dopamine. The absence of dopamine induces one of the symptoms of Parkinson's disease (a nerve disease characterized by tremors and muscle rigidity). The Parkinson's-like tremor is a common symptom of acute methyl alcohol poisoning," said Dr. Potts.

Since methyl alcohol must be oxidized before damage to the body begins, there is a period of time, as much as 24 hours, in which preventive steps can be taken to avoid injury.

The preferred treatment within this time is to administer large amounts of ethyl, or grain, alcohol—the same alcohol contained in whiskeys and beer.

"The enzymes in the body are selective for ethyl alcohol. If both types of alcohol are present, they will oxidize only the ethyl," states Dr. Potts. "Therefore, by maintaining a high level of ethyl alcohol in the body, we can keep the enzymes busy until the methyl alcohol is excreted by the body, thereby avoiding both acidosis and damage to the brain and optic nerves."

The treatment does have its drawbacks, according to Dr. Potts.

"When the administration of ethyl alcohol is discontinued and the patient regains consciousness, he has a heroic hang-over."

---

### **Feds Spend \$500 Million a Day**

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## State Control

*(Continued from page 115)*

This could be a "B" agency of Comprehensive Health Planning, a local hospital planning committee or any other local group. Next, the plan should be submitted to a health facility and related service planning agency within the State Department of Public Health. This agency could consist of 13 members, with one member representing each of the following: hospitals, physicians, nursing homes, Blue Cross, the health insurance industry, the governor and the public at large.

The agency could not veto any plan, but could determine that no public funds be spent either building a facility or providing a service. The planning developed under this proposal would be utilized to discourage the use of state funds for the purchase of care in unplanned facilities.

First of all this arrangement provides that plans must originate in the local area where the need is known. It does not provide for dictatorial police in the health department as did S.B.-1145. It does, however, discourage the establishment of unneeded facilities since few would wish to invest in a unit if they knew in advance no public funds could be obtained to help build or even pay for services in the proposed venture.

Doctor Yoder plans to call another meeting of all interested parties in the near future and it has been agreed that no new bill is to be introduced in the legislature by anyone until then. It is believed a bill that is acceptable to all can be prepared. ◀

*Ernest Breed M.D.*

## Malpractice target

*(Continued from page 166)*

We need to develop mutual understanding and cooperation on the part of the medical and legal professions, because there is much more to gain by cooperation and working together for the betterment of society. It is clear that the doctors and lawyers should combine their efforts and exert them to formulate a new prescription to combat the ills that plague both the legal and medical professions and do not always serve the public's interest. ◀



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**INDICATION:** Relief of insomnia of varied etiology.

**CONTRAINDICATIONS:** Patients with known hypersensitivity to the drug.

**WARNINGS:** Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

**Physical and Psychological Dependence:** Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

**Usage in Pregnancy:** Weigh potential benefits in pregnancy, during lactation, or in women of child-bearing age against possible hazards to mother and child.

**PRECAUTIONS:** If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

**ADVERSE REACTIONS:** At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.



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## the viewbox

*(Continued from page 133)*

**DIAGNOSIS:** Traumatic herniation of the right hemidiaphragm

With rupture of the right leaf of the diaphragm, there may be a herniation of the liver, and less frequently other intraabdominal organs, usually the small bowel. A split in the muscle occurs most commonly in the anteromedial aspect. Radiographically a gas-filled loop of bowel in the right thorax is diagnostic. Most commonly, the liver alone herniates into the thorax and the herniated liver must be differentiated from a high, paralyzed right leaf of the diaphragm as seen in eventration or from infrapulmonary effusion (a lateral decubitus will quickly demonstrate the fluid running along the lateral chest wall). With the herniated liver, the liver edge is seen to be high in position with the hepatic flexure of the colon, rising rather high in the abdominal cavity. A pneumoperitoneum is a valuable diagnostic tool, as a small amount of gas introduced into the abdomen passes into the right pleural space, unless the liver is incarcerated. The presence of a small pneumothorax is conclusive. In our case, an IV cholangiogram demonstrated the gall bladder to be elevated in position and rotated on its axis with the fundus pointing superiorly, a diagnostic hint that the liver was indeed in the chest cavity. The induced pneumoperitoneum outlines a small portion of the right diaphragm medially but is defective in its antral portion. Similarly, an isotope scan of the liver will demonstrate its position in an unusually high location suggesting its presence within the thoracic cavity.

The patient was operated on and successfully repaired by Dr. John Keeley.

---

### **"Pathogenesis of Anemia"** *Film now available*

The major types of anemias, their differentiation, tests involved in establishing the specific type, and some basis for therapy are discussed in "Pathogenesis of Anemia," a 16 mm, 30 minute film. Contact: National Medical Audiovisual Center (Annex), Station K, Atlanta, Ga. 30324.



# illinois medical journal

volume 139, number 3

March, 1971

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Abstracts of Board actions .....	219
----------------------------------	-----

clinical articles	Teenage maternal mortality in Chicago (1956-1968) <i>Robert E. Lane, M.D. and Murray Brown, M.D.</i> .....	241
	Ischemic colitis—a case report <i>Ramaswamaiah Chandrasekhara, M.D. and Ruven Levitan, M.D.</i> .....	266

surgical grand rounds	Dissecting thoracic aneurysm .....	246
-----------------------------	------------------------------------	-----

medical progress	The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease (Part 2) <i>E. Richard Blonsky, M.D.</i> .....	250
---------------------	---	-----

special articles	The critically injured patient: A plan for the organization of a statewide system of trauma facilities <i>Bruce A. Flashner, M.D. and David R. Boyd, M.D.C.M.</i> .....	256
---------------------	---	-----

features	the presidents page .....	233
	obituaries .....	235
	membership forum .....	236
	the viewbox .....	245
	socio-economic news .....	271
	medical legal review .....	273
	practice management .....	274
	what goes on .....	279
	new pharmaceutical specialties .....	284
	ckg of the month .....	286
	editorials .....	288
	the doctors library .....	290
	imaa report .....	292

(Cover story on page 235)

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**MONROE COUNTY:** Waterloo; population: 4500. Trade area: 8,500. Six physicians. Nearest hospital at Red Bud, 14 miles. Twenty-five miles from St. Louis. One prescription drugstore. Office space available. Predominant nationality—German. Many commuters to St. Louis. Four Catholic and Protestant churches. Grade and high schools. Local country club has golf course and swimming pool. For further information contact: Thomas S. Wightman, secy., Waterloo Chamber of Commerce, 127 South Main, Waterloo. Phone: 618-939-6218.

**OGLE COUNTY:** Oregon; population: 3555. Two physicians, urgent need for more. Nearest hospital at Dixon. Twenty-five miles from Rockford. Two prescription drugstores. Office space available. Agriculture and industry. Ten Protestant and Catholic churches. Grade and high schools. Recreational facilities include golf, swimming and two state parks. For further information contact: Jean R. Davis, Oregon Chamber of Commerce, 122 North 4th Street, Oregon. Phone: 815-732-2461.

**RANDOLPH COUNTY:** Sparta; population: 4000. Trade area: 10,000. Group in need of associate. Salary for a few months; early opportunity for partnership. Office provides two examining rooms for each physician. X-ray available. Two other physicians in town. Sixty-three bed local hospital. Coal mining and industry. Protestant and Catholic churches. Local country club with golf course. Thirty-five miles from Belleville. Fifty miles to St. Louis. For further information contact: W. W. Fullerton, M.D. or C. S. Schlageter, M.D., 101 North Market, Sparta. Phone: 618-443-2123.

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**Indications:** Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

**Contraindications:** Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

**Warnings:** Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

**Precautions:** Azotemia, hyponatremia, hypochloremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

**Adverse Reactions:** Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

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A study of Blue Shield claims has been made to determine the reasons why payments have been delayed and to help us make payments to physicians more promptly. By observing the following checklist, you can eliminate many delays involved in obtaining information needed to process your Physician's Service Report forms:

1. Correct group and subscriber number as shown on the patient's Blue Shield Identification Card. (Do not include the codes shown on the card.)
2. Correct spelling of patient's and subscriber's names.
3. Correct age of the patient.
4. Designate place of service (hospital inpatient, hospital outpatient, office, home).
5. Include dates of service, including date of admission and discharge from the hospital; date surgery was performed, if any; and number of daily hospital visits, if for medical care.
6. Indicate if an injury occurred at patient's place of employment.
7. Give details as to diagnosis, standard name of operation, if any, and sufficient descriptions, for example:

Vein Ligations: Stripping, multiple resections, both greater and lesser saphenous, unilateral or bilateral.

Lacerations: Location, length, depth and identify vessels, muscles and tendons repaired, if any.

(A copy of the operative report attached to the Physician's Service Report may be used).

When reporting surgical procedures, please do not use such names as "Strassman procedure" or "Nissen procedure". Payments will be made more promptly if you use standard medical nomenclature.

8. If any unusual situations are encountered, please describe them.
9. Check only the type of service personally rendered indicating date(s) and description of service(s). If other physicians have also rendered service, each must submit his own Physician's Service Report.

10. Indicate the fee for each service reported and indicate whether the fee has been paid by the patient.

This is particularly important in order to make payment to physicians on the basis of their Usual and Customary charges for those Blue Shield members who are protected by our Usual and Customary program.

11. On anesthesia claims, please provide the following information on the Blue Shield claim form:

(a) The time of the anesthesia

(b) The charge for anesthesia

(c) Particular attention should be given to claims submitted for anesthesia administered during a dilation and curettage of the uterus. Please indicate whether the procedure was performed for obstetrical purposes. It is suggested that you either provide the diagnosis or simply state dilation and curettage "obstetrical" or "nonobstetrical". This is necessary because of the high volume of claims submitted for this procedure.

12. Claims for radiation therapy are often delayed because the diagnosis is not included on the Physician's Service Report. By reviewing the claims before they are submitted to Blue Shield unnecessary delay can be prevented and the necessity to contact you for additional information can be avoided.

13. Personal signature of the physician.



## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

#### Attending Physicians in a Teaching Institution

We are frequently asked the question, "What is an attending physician in a teaching institution?"

Directives from the Social Security Administration state that to qualify as the "attending physician" for a period of hospital care, the teaching physician must as a minimum:

- a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress;
- b. personally examine the patient;
- c. confirm or revise the diagnosis and determine the course of treatment to be followed;
- d. either perform the physicians' services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level;
- e. be present and ready to perform any service enacted by an attending physician in a non-teaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and
- f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

The fulfillment of these responsibilities must be demonstrated, in part, by "notes and orders" in the patient's records that are either written by or countersigned by the physician.

A physician in a teaching setting who fulfills the requirements as an attending physician but does so for only a segment of a patient's hospital stay is still eligible for Part B reimbursement if that portion of the stay is "a distinct segment of the patient's cause of treatment"; i.e., a pre-operative or post-operative period. Also, the segment must be of significance in the continuity of the patient's care. If the teaching physician is not the "attending physician" for the duration of a segment, he can be reimbursed by Part B Medicare only for those identifiable services which he personally renders.

## Reimbursement for Hemodialysis Equipment

Medicare regulations allow your patient to be reimbursed for the rental or purchase of durable medical equipment if the equipment meets the following requirements:

1. it is customarily and primarily used to serve a medical purpose;
2. it can withstand repeated use;
3. it is generally not useful to a person in the absence of an illness or injury.

Durable equipment also must be necessary and reasonable for the treatment of a specific diagnosis and prescribed by you as the patient's physician. Also, the equipment must be used in your patient's home.

All Part "B" Medicare carriers have received a directive from the Social Security Administration indicating that hemodialysis equipment can be considered durable medical equipment when the above requirements are met.

Medicare will make reimbursement for two types of hemodialysis machines: the twin coil unit and the parallel flow unit.

Payment also may be made for repairs, maintenance and delivery as well as for expendable and nonuseable items necessary for the effective use of the equipment. However, no payment can be made for items such as blood pressure cuff, stethoscopes, forceps and scissors.

The decision to rent or purchase the equipment should be made by your patient. If your patient decides to purchase the equipment, monthly installment payments will be made either to your patient or to the supplier if he accepts an assignment. The monthly payments will be in amounts not to exceed the monthly rental charge.

Medicare also recognizes the possibility that a patient may need assistance in operating the equipment. Reimbursement can be made for training a lay person, such as a relative, to assist your patient when necessary.

#### S S A CERTIFIES NEW LABORATORIES

The following laboratories have been certified for Medicare participation by the Social Security Administration:

Miller Laboratory, Inc.  
123 A West Pearl  
Jerseyville, Illinois 62052  
Post Graduate Hospital Laboratory  
2400 South Dearborn Street  
Chicago, Illinois 60616  
Norven Medical Laboratory  
1816 West Irving Park Road  
Chicago, Illinois 60613  
P.M. Clinical Laboratory  
155 East Ohio Street  
Chicago, Illinois 60611

# *Abstracts of Board actions*

Board of Trustees Meeting  
January 16-17, 1971  
Sheraton-Blackstone Hotel, Chicago

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## **Medical Consultants to Develop Health Care Foundation Activity**

The ISMS Board of Trustees, at its January 16-17 meeting in Chicago, voted to contact professional medical consultants immediately, to develop a plan for Health Care Foundation activity in Illinois. The objective is to organize the physicians through a non-profit corporation for the purpose of participating directly in the administration of group health care delivery programs. Such a corporation, in cooperation with various prepayment plans, insurance carriers and government agencies, would enable physicians to retain leadership in health care delivery and to meet the requirements for peer review and other control mechanisms being discussed at the federal level. County medical societies considering establishment of their own foundations are urged to postpone implementation until an overall plan can be proposed to the ISMS House of Delegates. The ISMS Educational and Scientific Foundation will supply the funding for this initial study.

## **Physicians' Influence on Medicaid Crisis**

Members of the Board of Trustees have taken exception to the letter recently sent to Illinois physicians by the Bureau of the Budget outlining the financial crisis in the Medicaid program. The letter, in general, was a plea for cooperation from physicians in reducing the utilization of services under the program. However, because it carried a veiled threat of rigid standards being applied by the state, ISMS officers have met with representatives of the Illinois Department of Public Aid and the Bureau of the Budget to explain that physician fees and other costs over which physicians have some control were only partially responsible for spiraling Medicaid expense. The Board expressed resentment that doctors apparently have been singled out to hold down costs of a government program in which they have been trying to cooperate, sometimes at great odds with other extravagant forces. These points are being developed for distribution to the press.

## **Action to Improve Health Care Delivery**

In further efforts to improve the delivery of health care in Illinois, the Board has agreed:

1. To appoint representatives to a Joint Health Manpower Committee to cooperate with the Illinois Hospital Association in studying areas of manpower shortages and means to alleviate them.
2. To support legislation authorizing certification of physicians' assistants, if they are assigned only to doctors actively engaged in the private clinical practice of medicine.
3. To co-sponsor a conference to seek innovative approaches to current problems caused by legal decisions imposing liability on doctors and hospitals for injuries incurred during delivery of health care.



## **Approve \$968,650 Budget for 1971**

The Board of Trustees has reviewed and approved a 1971 operating budget of \$968,650. A balanced budget and no increase in dues is anticipated.

## **Alert Medical Societies to Local RMP Actions**

In response to information received regarding Bi-State Regional Medical Program officials going into two hospitals in Illinois to study medical records for educational purposes, the Board urges all physicians to keep alert to their vital role in government programs. It has also requested that the Bi-State RMP coordinate future activities with appropriate medical societies and that particular attention be paid to the legal aspects of physician and patient records.

## **Annual Meeting Information Available on Slides**

Highlights of the 131st annual meeting program and views of the 1971 convention site are included in a short slide presentation available to county medical societies. The Board expressed enthusiasm over the facilities and arrangements for medical self-testing, instructional courses, transportation, and horse-racing at the track adjacent to the Arlington Park Towers, where the meeting will be conducted May 17-19.

## **Legislation Being Supported by ISMS**

The Board of Trustees has accepted the Legislative Council's recommendations that ISMS support the following in the 1971 General Assembly:

1. An amendment removing liability for any foreign substance intentionally allowed to remain in the body.
2. A new bill, containing an emergency clause, declaring blood and human tissue services, rather than products.
3. Implied Consent to testing driving capability while under the influence of alcohol and drugs as proposed by the Governor's Committee on Traffic Safety.
4. Abortion legislation consistent with the ISMS position in the event that the present Illinois law is declared unconstitutional or that passage of an unsatisfactory bill is imminent.

## **Family Practice Departments: Where Are They?**

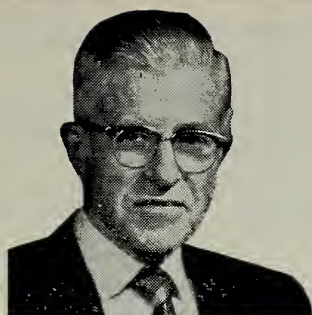
Declaring that state operated Illinois medical schools are making little headway toward developing departments of family practice, as they are legally required to do, the Board will ask the deans for written progress reports. If these reports are unsatisfactory, ISMS will consider requesting the General Assembly to appoint a commission to investigate why it is taking so long for the schools to implement its instructions.

## **Board Meeting to Be Streamlined**

In order to streamline its meetings and cut costs, the Board has adopted the following procedures:

- a. Saturday sessions will be restricted to officers, trustees, legal counsel, key staff personnel from state and county medical societies, officers of the AMA delegation and specific individuals invited to report to the closed session.
- b. The Sunday morning meeting will be devoted to reports by Council and Committee chairmen, officials of state agencies, third party insurance representatives, and such invited members, medical students, paramedical personnel, or others who have reason to appear before the Board.

*(Continued on page 294)*



# the presidents page

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## Legislation and you

Over 28,000 bills or resolutions were introduced into the 91st Congress, of which 2,000 concerned health or medicine. Over 5,000 were introduced into the 76th Illinois General Assembly, 300 related to medicine. In the 92nd Congress and the 77th Illinois General Assembly the number of bills to be considered will exceed those figures.

Because of their overwhelming workload and inadequate staffs, most legislators do not have an opportunity to study the multitude of bills under consideration. Consequently, only a few of the medical bills are thoroughly analyzed as to their implications. And these are the bills with which physicians should be actively concerned.

I realize that the increasing responsibilities of our practices and families leave little time for other matters. So it was a few years ago in Quebec, and when the physicians awoke they found that a law had been passed enabling the Provincial Primer to establish socialized medicine and make it impossible to practice medicine

outside the system. It would be unlawful even for them to give their services away. Fortunately, for the people of Quebec, this law was recently declared unconstitutional.

Due to rising costs and increasing demands for medical services, our medical care delivery system is destined to undergo drastic changes in the immediate future. Thanks to the efforts of the American and Illinois Medical Political Action Committees (AMPAC and IMPAC), many of our legislators are aware of the significance of pending medical legislation, and will do their utmost to preserve the doctor-patient relationship and quality medicine for all.

The legislative bodies are now in session in both Washington and Springfield. Significant medical bills presented in the national and state legislatures are being carefully analyzed and reported to you by the AMA and ISMS.

In trying times, such as these, it is important to become acquainted with our senators and representatives and make them aware of our needs on specific bills. If you fail to take part in the legislative process, you may be threatened with involuntary servitude as were the physicians in Quebec.

Do your share. Join IMPAC and AMPAC and help elect sensible representatives.

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### ***Inflation and family income***

It takes an annual income of more than \$10,000 for a family to live the way it could with only \$4,000 in 1940. Inflation has so eroded our currency that a 1940 dollar is worth only 36¢ today.

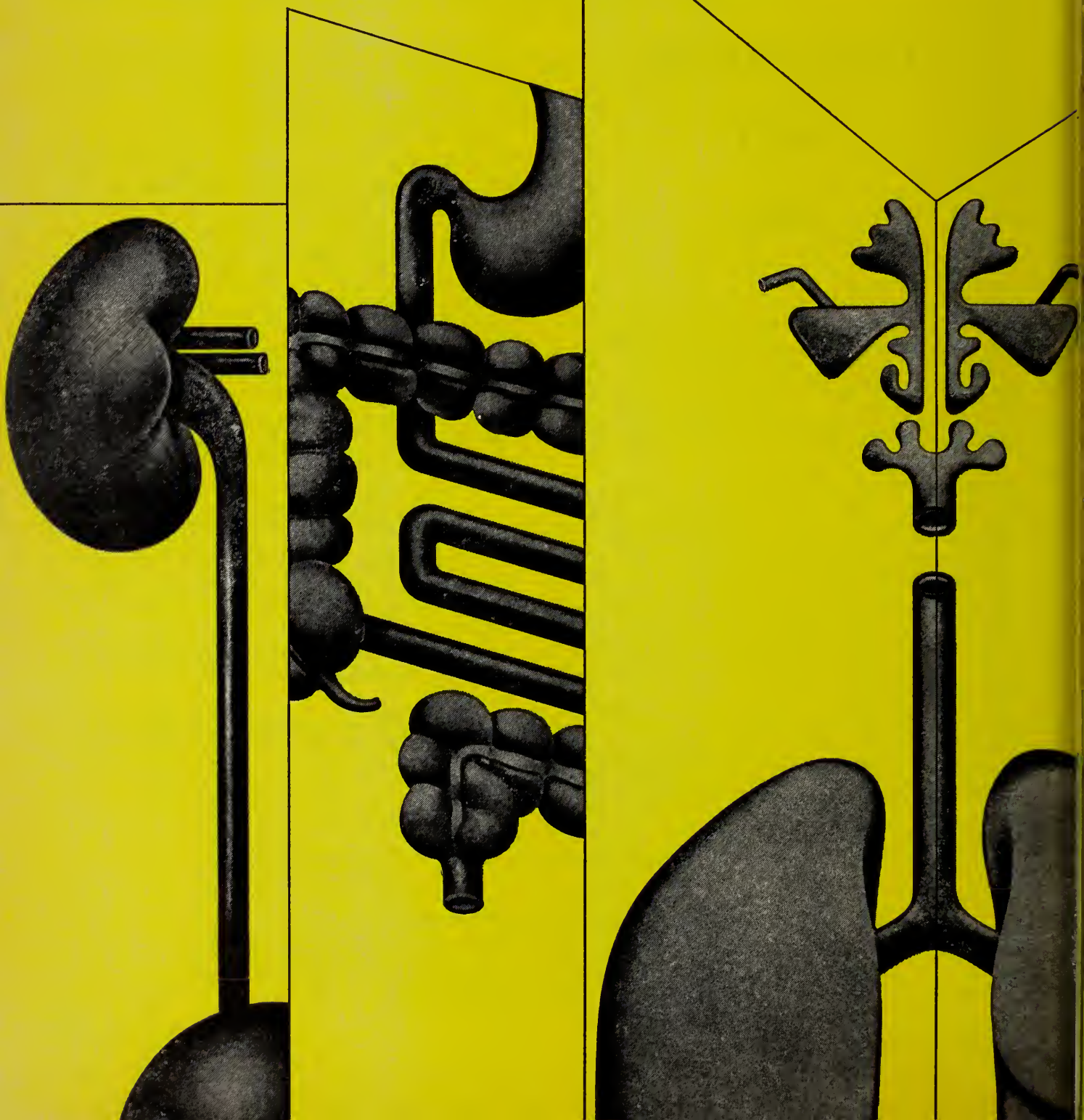


# Tract Record.

A record of clinical efficacy in treating bacterial infections of the respiratory, genitourinary and gastrointestinal tracts caused by susceptible strains of pneumococci, H. influenzae, staphylococci, streptococci, Klebsiellae, E. coli, Enterobacter, Shigella.

A record of years of dependable broad-spectrum activity.

A record of high urine and serum antibiotic levels all with a 500mg. potency, b.i.d. convenience and low prescription cost.



# Tetrex<sup>®</sup> bidCAPS<sup>®</sup> (500mg. tetracycline phosphate complex)

For complete information consult  
Official Package Circular.  
(3) 4/2/70

**Indications:** Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. In staphylococcal infections, indicated surgical procedures should be performed.

**Contraindications:** Hypersensitivity to tetracyclines.

**Warnings:** Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used and serum estimations may be necessary during prolonged therapy. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

**Precautions:** Mycotic or bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of 4 months.

**Adverse Reactions:** Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

**Usual Adult Dose:** One Gm./day in 2 or 4 equally divided doses. Continue therapy for ten days in Group A beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

**Supplied:** Capsules—250 mg. in bottles of 16 and 100. bidCAPS—500 mg. in bottles of 16 and 50.

A.H.F.S. Category 8:12

**BRISTOL**

BRISTOL LABORATORIES  
Division of Bristol-Myers Co.  
Syracuse, New York 13201

## Obituaries

\***Bernard Arons**, Lincolnwood, died January 18, at the age of 54.

\***Martin Basch**, Chicago, died January 18, at the age of 77.

\***James E. Breadon**, Chicago, died January 2, at the age of 51.

\***Harold M. Brill**, Chicago, died January 6. He was a member of the Chicago Board of Health.

\***John R. Duffey**, Rosiclare, died January 7, at the age of 54.

\***Hugh B. Fox**, Sun City, Calif., died Dec. 6, at the age of 75. He was a retired member.

\***Charles E. Gavin**, Chicago Heights, died in January, at the age of 45.

\***John J. Gearin**, Chicago, died January 1, at the age of 81. He was a member of the ISMS Fifty-Year Club.

\***William H. Harridge**, Evanston, died January 23, at the age of 51. He was clinical professor of surgery at the University of Illinois College of Medicine and past president of the North Shore Branch of the Chicago Medical Society.

\***Bernard Kleppel**, Evanston, died January 20, at the age of 52. He was assistant professor of radiology at the Chicago Medical School.

\***Forest C. Parker**, Danville, died Dec. 26, at the age of 65.

\***Sam C. Udell**, Chicago, died January 16, at the age of 66. He was a former trustee of the Chicago Medical School.

*\*Indicates member of the Illinois State Medical Society.*

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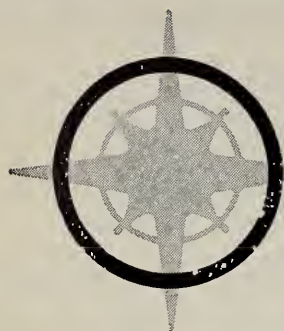
### ON THE COVER

Accidents—highway, home, industrial and farm—rank as the third worst killer and the leading killer of persons under the age of 40.

This month's cover depicts the problem and the article beginning on page 256 proposes a solution; an organized statewide system of specialized trauma units for treating emergency accident victims.

Written by Drs. Bruce A. Flashner and David R. Boyd, such a proposal was announced at a press conference some two months ago by Illinois Governor Richard Ogilvie.





## membership forum

### *A reply to Viewbox "Steak-eater's" criticism*

February 11, 1971

Dear Dr. Van Dellen:

I would like to reply to the letter of Dr. Charles J. Sigmund, Jr., which appeared in the January, 1971, *Illinois Medical Journal* in which he takes issue with a case that was presented in the November, "Viewbox."

I have had occasion since his letter to discuss his particular differences with some of the leading chest surgeons in the Chicago area who are basically in agreement with my comments regarding meat foreign bodies in the distal esophagus and the use of meat tenderizer as a treatment.

IN ALIMENTARY TRACT ROENTGENOLOGY, by A. Margulis, Volume II, page 1174, in an article by Dr. Walter Palmer, he makes the following statement, "Physiological narrowing of the esophagus occurs at three points of some clinical significance; particularly in patients who have ingested foreign objects. . . . The third point of physiological narrowing is located at the diaphragm where large chunks of meat or other food may stick, and fail to pass—a form of 'steak-eater's disease.'"

I have personally had occasion to examine five patients who have ingested a meat foreign body without bone who were successfully treated by using a meat tenderizer who have not had an episode of this syndrome before this initial encounter. At no time had they ever complained of dysphagia. These people usually gave a history

of swallowing an unusually large bolus of meat or having poor dentition, or having not sufficiently chewed the meat to allow it to pass without causing a temporary obstruction. Normal esophagrams several days later were obtained in all these cases. While occasionally esophagoscopy has demonstrated a lesion in the esophagus not visualized by barium esophagram, the reverse in my experience has been a far more common occurrence.

I have also had occasion to see two perforations resulting from esophagoscopy removal of meat bolus and the consequences of this occurrence were far more serious than giving a meat tenderizer to a patient who has an edematous esophagus.

To make my position clear, undoubtedly there are cases where organic pathology results in sudden obstruction of the esophagus. I think that there are far more cases where there is no organic basis and the patient is best treated by the use of an oral meat tenderizer or by allowing it to drip through a Levine tube until the bolus disappears. Certainly the patient's relief is beyond question. If there is any doubt about the appearance of the esophagus on the follow-up esophogram at this time I feel esophagoscopy has a proper place in the treatment.

Sincerely,  
Leon Love, M.D., Chairman  
Department of Radiology  
Loyola University Hospital



IMJ  
*Illinois Medical Journal*

# Teenage maternal mortality in Chicago (1956-1968)

BY ROBERT E. LANE, M.D. AND MURRAY BROWN, M.D./CHICAGO

From 1956 through 1968, 23 maternal deaths among teenagers occurred in Chicago, exclusive of those deaths occurring at Cook County Hospital. This represents 7.3% of all such maternal deaths during those years and indicates that teenage maternal deaths are a significant part of the total maternal mortality. This report is a summary of the known facts surrounding the foregoing deaths and the judgments of a special maternal mortality committee which has studied and analyzed those facts. Sixty-five per cent of the deaths had preventable factors.

## Materials and Method

All maternal deaths occurring in Chicago, exclusive of those at Cook County Hospital, are reviewed by the Subcommittee on Maternal Mortality of the Maternal and Child Health Advisory Committee to the Chicago Board of Health. This subcommittee studies abstracts of the hospital records of the deceased subjects, conducts an open discussion of the records with the attending physicians responsible for the care of the deceased subjects, and attempts to find any preventable factors in the causation of the deaths.

The deaths are classified as maternal deaths, from direct or indirect obstetric causes, with or without preventable factors, or maternal deaths from non-obstetric causes. In this manner, the subcommittee performs an invaluable service to the Chicago Board of Health, which is charged by law with the regulatory functions of all maternity divisions of licensed Chicago hospitals, and of greater importance provides an instrument of learning for persons concerned with obstetrics and the prevention of maternal mortality.



Results of study

Table I depicts the age, marital status, and race of the deceased subjects. The majority of the subjects were single and non-white, which permits postulation that socio-economic factors played a significant, if not dominant role, in the causation of the deaths. In a retrospective analysis such as this, epidemiological causes of death can never be learned; however, the presumed epidemiological causes for the majority of these deaths effect an obvious need for the collective capacities of public health agencies, private medicine, and society in general, to find the solution to the tragedy of teenage maternal mortality.

Table I

Relationship of Age, Race, and Marital Status to Teenage Maternal Mortality

Age In Years	Number of Subjects	Marital Status		Race	
		Married	Single	W.	Non-W.
15	2		2		2
16	3		3	1	2
17	6	2	4	1	5
18	6	3	3	3	3
19	6	4	2	2	4
Total	23	9	14	7	16

The causes of death in descending frequency and their incidence of preventable factors are as follows:

	Cases with		Percent
	Number of Cases	Preventable Factors	
Embolism	7	3	42.8
Toxemia	5	4	80.
Hemorrhage	4	4	100.
Infection	4	2	50.
Anesthesia	2	2	100.
Sickle cell disease	1	0	0.
Total	23	15	65.2

Each of the above deaths is abstracted below and the judgment of the Maternal Mortality Subcommittee concerning each death is stated.

The following obstetric conditions or complications and methods of termination of pregnancy were significant in the causation of the deaths:

	Number of Cases
1. Eclampsia .....	5
Three of these subjects were delivered vaginally, one subject had a Cesarean section, and one subject died undelivered.	
2. Illegal abortion .....	4
Two of these subjects died from air embolism, and two others died from sepsis.	
3. Cephalo-pelvic disproportion .....	3
Two of these subjects died from anesthesia causes, and one subject died from pulmonary embolus.	
4. Uneventful vaginal delivery .....	3
One of these subjects died from pulmonary embolism, one subject died from postpartum hemorrhage as a result of uterine atony, and one subject died from postpartum sepsis.	
5. Ectopic pregnancy .....	2
One subject died at home from ruptured tubal pregnancy, and one subject operated upon died from a pulmonary embolus.	
6. Ruptured uterus .....	2
One of these subjects had had a previous Cesarean section, and one subject had a spontaneously ruptured uterus.	
7. Elective repeat Cesarean section .....	2
Each of these subjects died from pulmonary embolism.	
8. Shirodkar procedure .....	1
This subject died from sepsis.	
9. Sickle cell disease .....	1
This subject died undelivered.	



ROBERT E. LANE, M.D., (left) is assistant professor, Department of Obstetrics and Gynecology, Northwestern University Medical School, and senior attending physician in OB-GYN at Chicago Wesley Memorial Hospital. He received his M.D. degree from the University of Illinois College of Medicine. Dr. Lane is also a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology.

MURRAY C. BROWN, M.D., (right) is Commissioner of Health, Board of Health, in Chicago. Dr. Brown received his M.D. from the University of Virginia, and has been active in the public health field.



**Death from Pulmonary Embolism**  
**(Four cases, one case with preventable factors)**

**Case Number 1:**

Age 15 years, single, non-white, G2 P1. First pregnancy terminated by Cesarean section because of eclampsia. Present prenatal course uneventful. Subject had elective repeat Cesarean section at 38 weeks gestation under spinal and cyclopropane anesthesia with delivery of normal 6 pound 5 ounce infant. On the fourth post-operative day, the subject experienced pain in her right arm followed by a generalized convulsion, shock and death. Autopsy revealed pelvic venous thrombosis with pulmonary embolism.

*Committee judgment:* Obstetric death with no preventable factors.

**Case Number 2:**

Age 18 years, married, non-white, G2 P1. First pregnancy terminated by Cesarean section for cephalo-pelvic disproportion. Present prenatal course uneventful. Elective repeat Cesarean section performed at 38 weeks gestation under spinal anesthesia with delivery of normal 7 pound 1 ounce infant. The subject died suddenly of respiratory distress nine hours after delivery. Autopsy revealed pulmonary embolus secondary to pelvic venous thrombosis.

*Committee judgment:* Obstetric death with no preventable factors.

**Case Number 3:**

Age 17 years, married, white, G1 P0. Subject underwent examination under anesthesia, dilatation and curettage, and laparotomy for unruptured left tubal pregnancy. A left salpingectomy and incidental appendectomy were performed. The subject collapsed and died on the third postoperative day. Autopsy revealed acute pulmonary embolism from pelvic venous thrombosis.

*Committee judgment:* Obstetric death with no preventable factors.

**Case Number 4:**

Age 18 years, single, white, G1 P0. Uneventful prenatal course. Subject entered hospital at 41 weeks gestation, irregular contractions, cephalic presentation, head floating, BOW I, cervix partially effaced, 1 cm. dilatation. After 24 hours of irregular contractions, cervix was effaced, 1 cm. dilated, and head was at -1 station. Twelve hours later, subject was having regular contractions each three minutes. Cervix was 3 cm. di-

lated and head was still unengaged. Three hours after above findings, subject had a Cesarean section performed because of cephalo-pelvic disproportion. A 9 pound 3 ounce living infant was delivered. On the third post-operative day, subject had low grade fever, distended abdomen, emesis and tachycardia. Paralytic ileus was diagnosed. Four hours later, clinical shock occurred. Gastric suction started at that time. Nasal oxygen was given. Abdominal paracentesis yielded 30 cc. yellowish liquid.

Chest X-ray and examination of lungs effected a diagnosis of pulmonary embolism. Twelve hours after initial onset of problem, a left thoracotomy was performed and embolectomy attempted. No embolus was found. Subject died from cardiac arrest the following day. An autopsy was not obtained.

*Committee judgment:* Obstetric death with preventable factors of delayed diagnosis of cephalo-pelvic disproportion with delayed definitive treatment of same, delayed treatment of paralytic ileus, and delayed diagnosis and treatment of presumed pulmonary embolus.

**Deaths from Air Embolism**  
**(Two cases, each with preventable factors)**

**Case Number 1:**

Age 17 years, single, non-white, G1 P0. This subject was found dead in bed at her home. The autopsy revealed an intrauterine pregnancy with a 3.3 cm. fetus, hemorrhagic changes with clot formation under one half of placenta, evidence of trauma to cervix and cervical canal, and free air in heart and arterial system.

*Committee judgment:* Obstetric death with preventable factors assigned to patient and abortionist.

**Case Number 2:**

Age 17 years, single, non-white, G2 P1. Subject attempted to abort herself with a wire coat hanger. She was dead on arrival at a hospital. An autopsy revealed evidence of attempted abortion and air emboli.

*Committee judgment:* Obstetric death with preventable factors assigned to patient.

**Death from Amniotic Fluid Embolism**  
**(One case, no preventable factors)**

**Case Number 1:**

Age 19 years, married, white, G2 P1. No prenatal care. Subject was seen in a hospital emergency room with complaint of vaginal spotting. Examination revealed a normal intrauterine pregnancy of 18-20 weeks with slight bleeding



from external os. Subject hospitalized and discharged after three days. Two weeks later, the subject re-entered the hospital with loss of amniotic fluid and in labor. A 2 pound 2 ounce living infant was delivered uneventfully. The placenta was retained. Two hours later, the placenta was manually removed under ether anesthesia. A few hours later, the subject had convulsions, respiratory arrest and expired. An autopsy was not obtained.

*Committee judgment:* Obstetric death with no preventable factors. Committee unable to substantiate diagnosis of amniotic fluid embolus without autopsy.

### **Deaths from Toxemia**

#### **(Five cases, four with preventable factors)**

##### **Case Number 1:**

Age 19 years, married, non-white, G3 P2. Subject had three prenatal visits. Records show the subject had gained 29 pounds during the pregnancy. A week following the last prenatal visit, the subject entered the hospital in coma. The blood pressure was 170/110, pupils constricted, lower extremity pitting edema, 4+ albuminuria, and intrauterine pregnancy of 30-32 weeks. A diagnosis of eclampsia was made. The subject received supportive therapy, had spontaneous labor and delivery of a small stillborn infant on day of admission. She developed oliguria, and subsequently expired on the fourth postpartum day. An autopsy was not obtained.

*Committee judgment:* Obstetric death with preventable factors of inadequate prenatal care and failure of physician to hospitalize subject on last prenatal visit for evidence by weight of excessive retention of water.

##### **Case Number 2:**

Age 19 years, married, white, G2 P1. Admitted to hospital at 38 weeks gestation with blood pressure of 160/120, edema and albuminuria. Discharge from hospital three days later on anti-hypertensive medication even though complaint of headache was present. Subject had blood pressure of 178/102 in clinic four days later. One week later, the subject entered the hospital in labor with headache, blurred vision, blood pressure of 190/122, and 4+ albuminuria. Convulsions and coma developed shortly thereafter. A Cesarean section under general anesthesia was performed, with delivery of a live infant. The subject expired twelve hours after delivery. An autopsy revealed cerebral hemorrhage, focal necrosis and hemorrhage in liver.

*Committee judgment:* Obstetric death with preventable factors of failure to treat definitively by termination of pregnancy the severe toxemia which the subject had on the first hospital admission.

##### **Case Number 3:**

Age 17 years, single, non-white, G1 P0. During prenatal course, subject was advised to be on low sodium diet because of excessive weight gain first noted at 20 weeks gestation, which was at the second prenatal visit. Four weeks later, subject was admitted to the hospital with slight generalized edema, lethargy, BP 180/155, 4+ albuminuria, unable to see, having epigastric pain and vomiting. The retina examination revealed bilateral exudative detachments. Supportive therapy was administered, and labor was induced by artificial amniotomy. A stillborn infant was delivered. The subject's condition progressively deteriorated with death occurring on the fourth postpartum day. Autopsy revealed subarachnoid hemorrhage, encephalomalacia, and lesions of toxemia in liver and kidneys. Eclampsia, cerebral hemorrhage, and bronchopneumonia were diagnosed as the causes of death.

*Committee judgment:* Obstetric death with preventable factors assigned to subject for failure to accept prenatal care.

##### **Case Number 4:**

Age 18 years, single, non-white, G1 P0. Prenatal course was essentially normal through the last prenatal visit two weeks prior to admission to the hospital. Subject was brought to emergency room having had two convulsions at home. Another convulsion occurred in the emergency room. BP 180/110, pulse 130, breech presentation, cervix uneffaced and closed. There was pretibial pitting edema and albuminuria. Supportive therapy was administered. Cardiac arrest developed on the second hospital day with successful resuscitation. Death occurred the following day. Spontaneous labor had occurred with delivery of stillborn twins weighing 5 pounds each just prior to death. An autopsy was not obtained.

*Committee judgment:* Obstetric death with no preventable factors.

##### **Case Number 5:**

Age 19 years, single, non-white, G2 P1. The first pregnancy terminated by Cesarean section for cephalo-pelvic disproportion. The subject

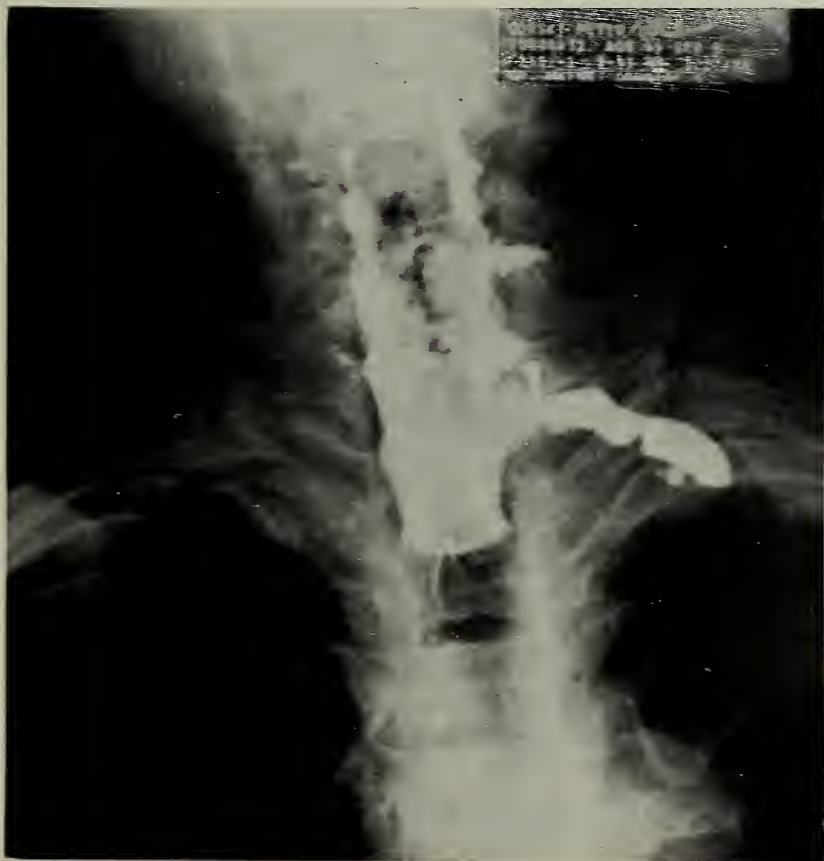
*(Continued on page 296)*



## the view box

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BY LEON LOVE, M.D./DIRECTOR AND CHAIRMAN, DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This 61-year-old patient was struck by a car and dragged along the street, on his side, with his arm outstretched and the side of his face along the ground. Physical findings: flaccid paralysis of the left upper extremity with complete loss of sensation. What's your diagnosis?

(Answer on page 296)





## surgical grand rounds

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Chicago Wesley Memorial, Passavant Memorial, and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds held on March 21, 1970.*

# Dissecting thoracic aneurysm

EDITED BY JOHN M. BEAL, M.D.

### Case Report:

**Dr. George Tolis:** A 44-year-old woman, previously in good health, experienced the sudden onset of severe chest pain. The pain started in the precordium and radiated to the shoulders and the lower back. She soon became very short of breath and vomited once. When she was admitted to Wesley five hours later, she was restless and appeared acutely ill.

Physical findings included blood pressure, 150/40 in the right arm, 120/40 in the left arm. A systolic bruit was heard in the left supraclavicular area. A harsh diastolic murmur was present along the left sternal border. An examination of the abdomen was unremarkable, and peripheral pulses were present and normal. X-rays were obtained.

**Dr. Abram Cannon:** We have chest and abdomen films which show nothing remarkable.

She has a rather short AP diameter of the thorax with some scoliosis of the thoracic spine. These changes distort the cardiac outline. The aorta appears normal, and the plain film studies are otherwise normal.

**Dr. Sheridan Meyers:** We used a retrograde approach from the right brachial artery through an arteriotomy and the catheter was passed retrogradely down to the ascending aorta. This was carefully positioned with multiple small hand injections of dye. During the initial part of the injection, the true aortic lumen is seen, and there is evidence of aortic insufficiency. Further into the injection, there is filling of the aorta and it appears that there is dissection throughout the aorta, including the descending aorta where the true lumen appears to be narrowed (Fig. 1). The false lumen became opacified and

a radiolucent line was seen which we believe represents intima. During the other angiogram, you will be able to see a little puff of contrast media enter the false lumen through what we believe to be the intimal tear (Fig. 2).

The intimal tear is  $1\frac{1}{2}$  to 2 cm. distal to the aortic valve. Our feeling was that this was probably a dissecting aortic aneurysm with some distortion of the aortic valve. There was no evidence of a shunt from the aorta to the right atrium or ventricle.

**Dr. Tolis:** The patient was taken to the operating room and the mediastinum was entered through a sternal splitting incision. The pericardium was opened and the ascending aorta was visualized. It was immediately apparent that a dissecting aneurysm was present. Cardiopulmonary bypass was instituted and the aorta was cross-clamped proximal to the branchiocephalic artery (Fig. 3). The ascending aorta was transected. The true lumen was then opened and a short cuff of the aorta, which included the intimal tear—a rather large and irregular one—was resected. Both ends of the transected aorta were oversewn circumferentially to obliterate the false lumen. The defect in the ascending aorta was bridged with a dacron graft and continuity was re-established. The aortic valve was not damaged by the dissection and was not replaced. During the procedure there were some difficulties in maintaining adequate perfusion but there were no serious sequelae. The patient has made a good recovery. There is no evidence of aortic insufficiency but a systolic bruit still persists, which is probably at the orifice of the left subclavian artery.

Dissecting aneurysm of the aorta is a highly lethal disease. Without treatment, 80% of the patients succumb within one month, 90% within one year, and the five year survival without treatment is close to one per cent.

The cause of death may be due to pericardial tamponade from hemorrhage into the pericardial sac, exsanguinating bleeding from rupture of the aneurysm into the pleural cavity, or obstruction to the flow of blood to the head or abdominal aorta by the dissection.



**Fig. 1.** An AP view of the thorax demonstrates the catheter in the ascending aorta. Contrast material has filled the ascending aorta, arch and the descending aorta. In addition, the left ventricular chamber is filled by contrast material which has entered it through an insufficient aortic valve. The proximal portion of the left coronary artery is also visualized. The contrast material is seen to fill the true lumen of the aorta, and this lumen is markedly narrowed and deformed by the false lumen of the dissecting aneurysm.

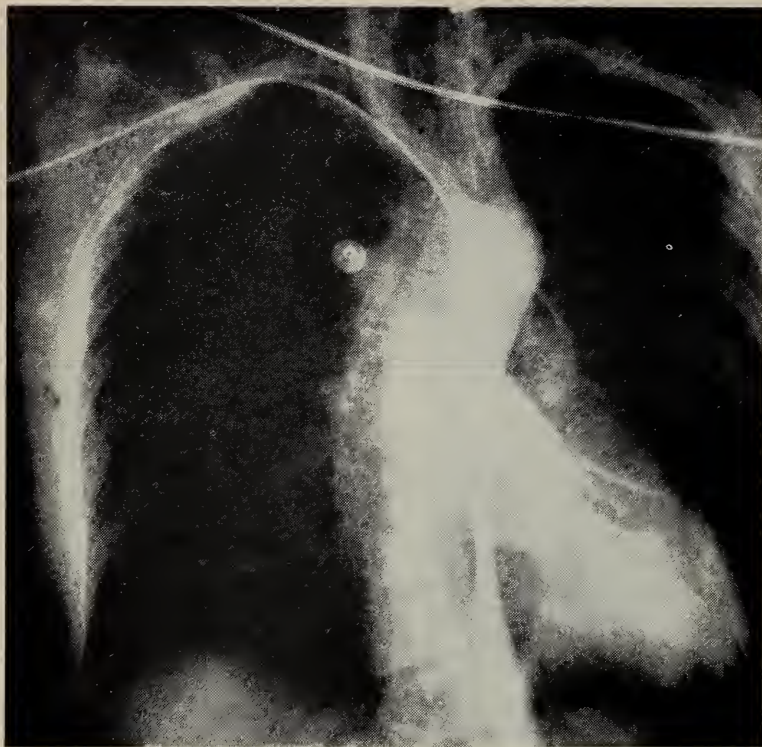
An aortogram is required to confirm the diagnosis and locate the site of the tear. The surgical approach is through a median sternotomy, if the tear is in the ascending aorta, and through the left pleural cavity, if the tear is located in the descending aorta.

Location of the tear in the ascending aorta is more common in patients with Marfan's syndrome and in those with skeletal defects such as scoliosis or pigeon chest. The great majority of these patients are not hypertensive. In patients with arteriosclerosis and hypertension, the intimal tear is found most commonly in the descending aorta, just beyond the origin of the left subclavian artery.

The objective in treatment is to stop the dissection. In hypertensive patients, this can be accomplished with hypotensive medications which lower the blood pressure to a systolic level of 90-100 mmHg., providing there is adequate urine output.

Surgery is indicated in patients who are not hypertensive, when the conservative approach





**Fig. 2.** The film demonstrates a widened aortic root. In addition, to the right of the catheter is seen a small radiolucent line which represents the intima of the aorta and further to the right of this is seen contrasting material which has entered the false lumen of the aorta.

fails to control the dissection, or if there is severe aortic insufficiency or obstruction of a major branch of the aorta.

The surgical repair of the tear does not always guarantee a good final result, especially in patients with dissection due to cystic medial necrosis of the aorta. Such was the case of a 20-year-old man with typical Marfan's syndrome, who developed dissection of the ascending aorta complicated by aortic insufficiency. The root of the aorta and the aortic valve were replaced with prostheses in another medical center. He died of congestive heart failure in our Center, three weeks later. At autopsy, he was found to have extensive dissection of the aorta from the distal end of the graft down to the renal arteries, with multiple intimal tears in the thoracic aorta. The true lumen was collapsed and the left ventricle was obstructed.

**Dr. Arthur DeBoer:** The points of major importance regarding dissecting aneurysms are that the diagnosis must be confirmed as soon as possible, so that therapy can be intelligently carried out, and what type of therapy should be instituted. It becomes obvious, in the two cases that were presented this morning, that clinical impressions are inadequate in making the diag-

nosis of a dissecting aneurysm. This was well demonstrated by the first case that was presented. In the second case presented, even though the onset of aortic insufficiency with the clinical history of sudden chest pain is quite characteristic of a dissecting aneurysm, the site of origin of the tear must still be determined should surgery be considered. The best way to confirm the diagnosis and identify the site of the tear is by means of aortography.

Patients with suspected dissecting aneurysms present a real challenge to any angiographic service. The patients are usually elderly and acutely ill, and some of the peripheral pulses may be absent. It is not difficult to obtain an aortic arch study in patients with a normal aorta, but in elderly people with tortuous vessels that are calcified, stenotic and even occluded, it is a much more difficult situation. In these patients, it is my impression that a percutaneous femoral approach for an aortic arch study is often inadequate and impossible to perform. A good angio-

graphic service, therefore, should have enough latitude in their performance to study these patients by means of a cutdown on the brachial artery. This approach enables one to pass a soft catheter up the brachial artery and with much manipulation, it usually can be guided into the ascending portion of the aorta. The arteriograms that Dr. Meyer has shown us this morning not only confirm the diagnosis, but also definitely identify the site of intimal tear. These films were done in the cardiac catheterization laboratory, and it is my opinion that this is an ideal place for this type of study, rather than in the radiology department where, should any kind of catastrophe occur, the facilities are exceedingly limited. In contrast, the catheterization laboratory is equipped and prepared for many types of problems that might arise during the angiogram.

After the diagnosis has been confirmed and the origin of the tear has been identified, the next problem is to make a decision as to the mode of treatment. There are those who feel that the primary treatment of a dissecting aneurysm is nonsurgical, primarily with the hypotensive drugs. There are others who feel that the best treatment of a dissecting aneurysm is surgical and the medical regimen is seldom, if



ever, in order. The confusion as to which means of treatment is best is probably because of the lack of knowledge of the natural history of the disease. As one reviews the literature, one obtains quite contrary impressions as to the incidence of the site of origin of the dissection, as well as mortality, with or without treatment. It becomes obvious that if one reviews the autopsy percentages, these figures do not include the surviving patients that later become chronic dissectors. The surgical reports, on the other hand, do not include those patients who died of the dissection prior to surgical treatment. The mortality figures also vary as the source of patients vary. A hospital, that obtains a large percentage of its patients through referral from other hospitals, sees the surviving patients in a greater number than a community hospital, where the early acute dissection is seen, followed by death within a couple of hours.

There is, however, a review of a rather small group of patients—numbering 62—over a period of approximately 14 years, which may be worth-

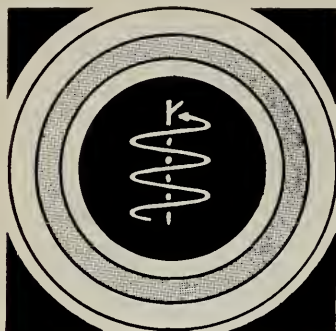
while reviewing. This was done in a large general hospital in which none of the patients were referred from other hospitals and one could assume this to be the natural history of the disease in its acute phase. It is interesting to note that 65% of the cases were found to have the site of origin of the dissection in the ascending thoracic aorta, 31% in the descending thoracic aorta, and four per cent in the transverse thoracic aorta. If this is an accurate natural history, then one can assume that the majority of dissecting aneurysms originates in the ascending thoracic aorta. It is also interesting to note in this study that there were no survivors longer than three weeks in patients whose dissection began in the ascending thoracic aorta. In contrast to the 100% mortality within three weeks of this group, there was a 50% survival of the patients who developed the dissecting aneurysm in the descending thoracic aorta. This suggests that if the dissecting aneurysm originates in the ascending thoracic aorta, the prognosis is ex-

*(Continued on page 298)*



**Fig. 3. Photograph at the time of operation demonstrates ascending aorta, site of dissecting aneurysm, as seen through median sternotomy.**





## medical progress

The first part of this article which appeared in the February issue of the *IMJ* dealt with the physical description of the patient afflicted with Parkinson's disease and described the methods, results and side-effects of cases in which the drug, L-DOPA was used. Rehabilitation methods were briefly mentioned in the first part and are continued in this second part.

BY E. RICHARD BLONSKY, M.D./CHICAGO

# The role of L-DOPA in the of patients with

### Rehabilitation methods

An identical therapy program is run for out-patients, though not on a daily basis. There has been no Parkinson patient who has not benefited from this treatment, including several who were not receiving levodopa. Even those who are quite demented are able to follow along with the group in rhythmical hand clapping, ball catching and throwing. Of greater importance is the fact that the carryover has been excellent. Patients remember the simple exercises and spontaneously practice at home or in their rooms, particularly those activities with which they have most difficulty. When rechecked several weeks later they usually can demonstrate the exercises and invariably reveal improved function. Such carryover was almost unheard of in the past with the use of "traditional" methods.<sup>18</sup>

There are many patients, both young and old, who for various reasons (usually neglect or ignorance) are permitted to develop severe contractures. The most common orthopedic disturbances include flexion contractures at the knees;

equinovarus position of the foot with marked heel cord shortening; toe flexor spasms; flexion and ulnar deviation at the wrist with metacarpophalangeal flexion and interphalangeal extension. In a selected series of patients, various orthopedic reconstructive procedures have been carried out with remarkable results. Such surgery is never contemplated until the patient has been maintained at a therapeutic dose of L-DOPA for at least three to four weeks in order to obtain optimal muscle loosening. Concurrent stretching of these muscles is carried out in physical therapy. When maximal range of motion has been obtained in this fashion, surgery is then utilized to correct the residual deformity.

About the ankle the most common procedure has been a Z-plasty lengthening of the tendo-achilles. A few severe cases have required triple arthrodesis to restore and maintain neutral position. Simple sectioning of the long toe flexors usually abolished spasms of these digits although proximal phalangectomy with syndactylization was required in a few instances. A few patients with marked adductor spasm have greatly bene-

fitted from subcutaneous sectioning of these tendons at the groin. Various tendons about the wrist and hand can be sectioned and/or transplanted in order to produce a functional hand with good pinch and grasp. These procedures have been described more authoritatively and in greater detail elsewhere.<sup>19</sup>

It should be apparent that the theme of the L-DOPA treatment program is one of total rehabilitation of the patient, both physical and psychological. The ward milieu encourages it; the physical therapy staff demands it. At the same time the nursing and medical staffs educate the family as to the benefits both for them and the patient if he is able to maintain independence in activities of daily living. Prior to discharge and at each subsequent examination the patient is questioned as to the scope of his activities about the house and community and is encouraged to increase his program within realistic limits. Many patients begin to drive again, join

capable of doing so. Several young women existed as vegetables in their own homes, unable to cook or clean, wipe a nose or apply a bandaid. Their children preferred to deal with the housekeepers while their husbands showed little ardor. These women felt themselves unwelcome guests in their own homes. As a consequence, moderate to severe depression was a common denominator among these younger patients and the concept of total rehabilitation had far greater meaning and urgency to them than to the older group. We soon recognized that the benefits of L-DOPA therapy were consistently greater among the younger patients whose brains, blood vessels and bodies were still pliable. The long range goals for these patients included much more hope for return to a truly normal existence than was true for the older patients. The following case reports illustrate some results.

*Case 1.* Patient C. W., a 46-year-old man, was a shipping clerk for a major manufacturer until

# functional rehabilitation Parkinson's Disease

senior citizens' groups, take up hobbies, etc. Obviously those patients in their late 60's and 70's have limited potentials for activity, but many of them returning to near-normal physical status, are in need of social and vocational programs outside the home. They face the same frustrations which plague other "golden agers" in this society but this is a problem unto itself.

Some of our major problems have arisen with respect to the younger patients and a sizable number fall into the under-60 age group. In many instances these patients had taken early retirements, either voluntarily or under pressure, and consequently had spent months to years literally sitting around, not only unproductive and not earning, but becoming increasingly dependent and physically immobile. In other cases job security was severely threatened because of the patient's disability, with some organizations keeping men on only out of a sense of obligation. The tremendous feeling of frustration one could sense in these younger patients was often overwhelming. Despite an intense urge to perform their job duties they were quite in-

he was retired on full pension and Social Security because of "total disability" one and one-half years before he entered the hospital. His illness had begun with tremor and stiffness of the left hand in 1963. He progressively developed rigidity of all limbs and the trunk, became markedly akinetic, suffered many falls because of gait disturbances, and was only barely independent in performance of activities of daily living. Examination revealed marked facial masking with unblinking stare, staccato speech and drooling. Marked rigidity of all limbs and trunk was noted, but only slight hand tremor was seen bilaterally. He was bent forward at the waist, the knees were flexed and he showed propulsive movements. Gait was festinating and shuffling with *marche a petits pas*. Alternating hand and finger tapping movements were very slow. He could neither turn over nor get out of bed unaided and could arise from a chair only after several attempts.

His score on the neurological examination before treatment was 21 and the score for A.D.L. performance was 10. His initial response to L-DOPA was negligible, and he became increasing-



ly dependent, negative and hostile. Suddenly one morning, after thirteen days of therapy, a dramatic transformation occurred. His trunk loosened, he straightened up, his stride became normal and his arms began to swing. He became able to jump up from a bed or chair and to all outward appearances seemed normal. Ten weeks after onset of treatment, while receiving a total dose of 6.0 g/day his score on neurological examination was 3 and on A.D.L. performance 0. His total improvement was 90%.

Discussion about his future plans in view of the almost total recovery, revealed his only goals were to be able to fish and resume dancing, two activities he had been forced to give up during his disability. The thought of working did not enter the picture. As he explained, the red tape involved in having himself taken off pension and Social Security was more than he cared to bother with, while even more significantly the amount of money he was collecting on the basis of "total disability" exceeded what he might be able to earn again as a shipping clerk. There was absolutely no incentive for change in this case.

This patient was lost to follow-up because he objected to taking repeat psychological and tremor studies. He was able to find another physician who was willing to accept him and who apparently introduced no moral stumbling blocks into the path of self-gratification the patient had chosen to follow.

*Case 2.* Patient M.O.K., a 36-year-old housewife, developed tremor of the right hand in 1963, and the left hand by 1964. Rigidity and akinesia became progressively worse. In 1967, a left cryothalamotomy was performed. A few hours after surgery the patient became unresponsive and exhibited paralysis of the right side of the body. Cerebrospinal fluid was grossly bloody and a subarachnoid hemorrhage was diagnosed. Moderate function of the right limbs returned slowly with the aid of intensive physical therapy. For several weeks the patient was mute, while later her speech was guttural and unintelligible. It was concluded that she was aphasic and in spite of continuous speech therapy no progress was made.

On admission she was unable to feed herself, perform any hygiene tasks, get out of a chair or bed alone, or stand alone. She stood *en point* on the left toes and circumducted the right leg stiffly when she was held up to walk. The right limbs were almost unmovable while the left were severely rigid. No tremor was seen. Her face was blank, she drooled continuously and speech consisted of a few grunts. Score on neurological

examination at the time was 45 and for A.D.L. performance was 42.

Treatment with levodopa produced gratifying results over the first two weeks. A gradual decrease in rigidity revealed a residual spastic hemiparesis on the right. All movements increased in speed and she became progressively self-sufficient. Her "aphasia" has subsequently cleared completely. She benefitted from a spring type short-leg dorsiflexion assist brace on the right foot and was discharged from the hospital after six weeks. Her evaluation scores after two months of L-DOPA treatment, on a dose of 5.4 g/day were 7 on neurological examination and 7 on A.D.L. evaluation. This represented an 85% improvement.

At home she resumed normal activities including housework, and cooking. She was able to speak to her three-year-old child for the first time and very quickly assumed her place as wife and mother. She later developed some head-bobbing and grimacing movements which diminished as the dose of L-DOPA was decreased, and is now maintained at 4.5 g/day without any loss of therapeutic benefits.

*Case 3.* Patient L.J.R., a 45-year-old woman, had developed parkinsonism in 1962, the first symptom, difficulty "getting moving," on the left side. Soon tremor developed, accentuated by activity, which interfered with her job as secretary for a large manufacturing firm. In 1964, a right cryothalamotomy was performed, resulting in abolition of tremor on the left side which enabled her to continue to work for another two years. By that time the disease had progressed markedly with tremor on the right side, severe rigidity and akinesia. Following retirement she was cared for at home by her elderly mother and soon reached a point of almost total immobility and dependency.

On admission her face was rigidly masked and unblinking. A stream of saliva drained from the left corner of her mouth, speech was unintelligible and voice was inaudible. Mild tremor of the right hand was noted, which increased under tension. Severe generalized rigidity of all limbs and trunk was noted with profound akinesia. She could not get out of a chair alone, stand unaided or take even one step despite bilateral support. Neurological examination score at that time was 55, and A.D.L. score 43.

The patient showed a prompt response to levodopa with a dramatic improvement noted in a month on a dose of 7.5 g/day. Because of moderate equinovarus position of the right foot, orthopedic reconstruction was performed. A heel

cord lengthening procedure was done, but dorsiflexion of the foot increased flexion spasm of the toes. For this reason proximal phalangectomies of the second to fifth toes were also carried out with syndactylization of toes 2 to 3 and 4 to 5. The patient continued her course of improvement and goals were established, including retraining for secretarial or clerical work. Vigorous physical and occupational therapy programs were followed. At the time of discharge her neurological score was 30 and A.D.L. score 11.

Soon after returning home the patient's mother became ill, entered a hospital and the patient was left alone in her apartment. She managed well for several months, continued to improve, and five months after starting levodopa therapy her neurological examination score was 12 and A.D.L. score 8. This represented an 80% improvement over her original performance. In April, 1969, the patient fell and sustained a fracture of the left hip requiring hospitalization. Upon recovery she was transferred to the nursing home in which her mother was a patient. For five months the patient obtained almost no physical therapy but was finally able to transfer to the Rehabilitation Institute of Chicago where she participated in a vigorous restorative program. Objectively she had lost no ground with regard to the effects of L-DOPA on her parkinsonism. She subsequently has left the Rehabilitation Institute for a nursing home which is the only available facility, although she really needs a supervised domiciliary arrangement. We have not been able to get her back to work yet nor is it likely that her depressive and pessimistic attitude will permit this degree of activation to take place.

*Case 4.* Patient M.D.H., a 45-year-old man, was employed as a foreman of a small machine shop. He first developed tremor of the left hand in 1965, with rapid spread to the left leg, but the right hand became involved just at the time he presented himself for treatment. His speech could not be understood; his movements had become quite slow; and he noted rigidity of muscles generally. Because he could no longer easily communicate with his workmen and had great difficulty ambulating, his job was plainly in jeopardy.

On admission he revealed marked facial masking and occasional drooling. There was moderate rigidity of the upper limbs and severe rigidity of the trunk. Minimal left hand tremor was seen. He shuffled while walking with loss of arm swing and *en bloc* movements of the body. Some festinating movements occurred. His voice was

very soft, speech was rapid and inarticulate. Neurological examination score was 25, the A.D.L. score 14.

Treatment with L-DOPA resulted in slow improvement in his condition but ten weeks later the neurological examination score was 7 and A.D.L. score 3. His gait had loosened considerably with long stride and arm swing present. All movements became easier to perform and were more quickly carried out. At a dose level of 4.0 g/day serious oro-buccal-lingual dyskinesias developed with gnawing and tongue-chewing movements. The dose was reduced to 3.0 g/day, then slowly increased with good tolerance. The patient is now able to speak loudly and clearly, can get around quickly and easily, and is firmly ensconced in his job at this time.

### Discussion

The four cases briefly presented here are truly representative of the younger Parkinson patient. The problems facing this group are numerous and serious. These people are mothers or fathers of young children to whom they do not present a satisfactory parental image. Their inability to work often means the difference between a family on the welfare rolls or one that is self-sufficient. The group is too young to have built-up financial reserves which would permit "rocking chair retirement" nor in general do they wish that type of existence. As a group, they tend to be hard-working and sincere, and only hope for an opportunity to perform at a job.

It is obvious that L-DOPA has a positive effect on parkinsonism and significantly modifies the symptoms and severity of the disease. It is quite reasonable to expect at least 50% improvement or better among the younger patients. One question that must be answered concerns itself with the type of patient who should be treated. Many investigators have stated that a person who is only mildly afflicted can do just as well with the standard antiparkinsonian drugs until his symptoms become sufficiently severe to warrant switching over to L-DOPA. It is our feeling that the person who most warrants treatment is the one who is not at the end stage; that arresting the disease at the stage of minimal involvement enables the individual to continue to function at a high level which can be maintained indefinitely. Accordingly, we feel that the sooner a parkinsonian can be diagnosed and treated, the more likely it is that he will be able to continue to live a completely normal existence.

Even those patients who get beyond this early



stage are salvageable and can easily be retained in various occupational positions whose demands would not exceed the skills of the patient. It is necessary, in the broad concept of total rehabilitation, to conceive of retraining centers which might develop new skills for those patients who have been restored to a functional level as well as more liberal policies of employment which would permit these people to re-enter commerce and industry. We feel it is important that disability rating boards recognize the existence of this new chemotherapeutic agent and the ancillary rehabilitation services, and do everything possible to get the parkinsonian into proper treatment areas so that he does not become a community liability.

Parkinsonism must be viewed from a new angle, not as an incurable progressive disease, but rather one which can be effectively treated. In cooperation with the neurological investigator, priority should be given to these younger patients so that they can remain as assets rather than become liabilities. Both medical and personnel administrators in industry must think in terms of rehabilitation and retention rather than release of the parkinsonian, so that full advantage of his experience and expertise may be obtained.

The cases reported present several interesting problems. Case 4 is the lucky one; he has his job and is physically able to handle it with a good sense of security. Case 1 has no job but is receiving sufficient compensation so that there is no incentive to return to work. As an excuse he blames governmental and industrial bureaucracy in order to maintain his *status quo*. It is true that if it were not so complicated to change his status from "totally disabled" to "able bodied," less resistance would be present.

Case 2 has had good results from L-DOPA treatment and has been restored to that life style to which she is entitled—wife, mother and companion. The fact that she also bears the scars of unfortunate neurosurgical sequella does not detract from the goal she has achieved.

Case 3 represents a situation of "overkill." Initially goals were set too high and too much pressure was applied for her to cope with. As a consequence she has become depressed, pessimistic, fearful of trying. She is in need of a "half-way house" situation in which she can slowly emerge into society as she learns skills and becomes proficient at them. Under those conditions, and with time, perhaps a useful citizen can be restored to the community.

## Summary

Levodopa is a potent chemical which can restore the balance of the catecholamine metabolic pathway in the basal ganglia of the brain. Its effectiveness in treatment of parkinsonism has been substantiated by numerous investigators and it represents the single, most useful agent in the treatment of this disease at this time. The benefits obtained include loosening of rigidity, decreased tremor, improved speed of movement, return of associated movements, improved autonomic function, etc. Various side-effects have also been common, most often involving the gastrointestinal or central nervous systems, but can usually be controlled by reduction of dose. The degree of improvement in all patients is generally high, especially in younger patients.

Representative case reports indicate the degree of improvement which is possible, even for patients who are nearly totally disabled. The emphasis in treatment is on total rehabilitation which must include restoring the patient to a useful and responsible position in society over and above regaining physical skills. It is urged that industry and commerce re-examine their attitudes toward the Parkinson patient in view of these new developments and that they lead the way in establishing restoration centers to retrain these people and modernize hiring practices so that the rehabilitated patient can find gainful employment.

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(Continued on page 300)



## public affairs

a service of the division of legislation and public affairs

### **Nixon:** *Promise to keep bureaucracy at minimum in national health program*

President Nixon promised that every effort will be made to keep bureaucracy at a minimum in connection with his new overall national health program even before he disclosed its details.

"... We do not want the doctors and those in the medical profession to be smothered under a whole, huge bureaucracy and under a great pile of government forms," he said in a speech at the 20th annual meeting of the American College of Cardiology prior to his acceptance of the college's 1971 Humanitarian Award.

Nixon said he recognized that there is no program for medical care that would be good for the patient unless it is supported by physicians and has the cooperation of the medical profession.

"So we want your advice, we want your cooperation, we want to work together with you in developing a program that will do what is needed to be done and do the best for our

patients, your patients, but also that will enable you to meet your responsibilities as unhampered as is possible by federal bureaucracy, red tape and the like," he said.

In the State of the Union message, the president said:

"I will propose:

- A program to insure that no American family will be prevented from obtaining basic medical care by inability to pay;
- a major increase in and redirection of aid to medical schools, thereby increasing the number of doctors and other health personnel;
- incentives to improve the delivery of health services, to get more medical care resources into those areas that have not been adequately served, to make greater use of medical assistants and to slow the alarming rise in the costs of medical care;

- new programs to encourage better preventive medicine, by attacking the causes of disease and injury, and by providing incentives to doctors to

keep people well rather than just to treat them when they are sick;

- an appropriation of an extra \$100-million to launch an intensive campaign to find a cure for cancer, and I will ask later for whatever additional funds can effectively be used."

"America has long been the wealthiest nation in the world. Now it is time we became the healthiest nation in the world."

In his budget message, Nixon said he later would send to Congress a message "that will set out a national health strategy for the seventies and propose significant changes in the federal role in the nation's system of health care."

"This strategy will seek to expand preventive care, to train more doctors and other health personnel, to achieve greater equity and efficiency in the delivery of health services," he said. "It will include a new health insurance program for all low-income families with children."

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### **More output from fewer workers**

One segment of the American economy where productivity continues to increase is agriculture. One farmer in this country today produces enough to feed 42 Americans, 20 more than in 1960.



BY BRUCE A. FLASHNER, M.D.

AND

DAVID R. BOYD, M.D.C.M./ILLINOIS

## The critically injured patient:

# A plan for the organization of a statewide system of trauma facilities

### Introduction

A plan to organize a statewide system of facilities for the treatment of the critically injured patient was recently proposed for Illinois. The focus of the approach is to define an easily identifiable segment of the emergency problem—that of the critically injured patient—and establish a network of statewide trauma units. The plan will provide adequately staffed facilities, linked together by a communications network, which is equipped for the comprehensive management of seriously injured patients.

The need for a comprehensive program is rapidly becoming evident to the consumer, governmental officials, physicians and many health organizations. At this very moment, in the State of Illinois, as well as throughout the country, someone is being seriously injured. As a result, he may face extensive physical disability, prolonged and costly hospitalization or even loss of life. These possibilities occur not because of disinterest in the problem by those concerned, nor even inadequate medical knowledge, lack of money, or equipment, but because the health establishment has been unable to provide a successful method for access to proper treatment and care.

There is presently a dilution of manpower and resources causing a crisis in the accessibility by the public to this type of specialized care. Interestingly, this accessibility is not of the mod-

ern fashionable type—bringing health care to the disadvantaged—for the poor have immediate recourse to the nearby “County” hospital with its fully staffed and equipped trauma service.

The recently published study on emergency services in the Chicago area documents the problems in the urban community.<sup>1</sup> There are also many studies throughout the country which have proposed solutions to the problems related to emergency service and emergency rooms, including the recent document from the Illinois Hospital Association.<sup>2</sup> It is believed that as this program proves successful it will act as the catalyst, as well as the foundation, upon which the solution to the total emergency care problem can be structured.

Since this is a proposal for a model, it will not describe at this time the minute details of organization, financial relationships or guidelines of function. Regionalization, financial disbursement of funds, administrative guidelines, involvement of voluntary organizations and possible legislation are some of the many aspects which will be evaluated.

McNerney, in a recent article, calls the health administration establishment an underachiever.<sup>3</sup> Kinzer, of the Illinois Hospital Association, proposes that immediate steps be taken to create a system of comprehensive emergency service planning.<sup>2</sup> The time and opportunity have come for this state’s health establishment, in conjunc-

tion with the state government, to solve a serious health problem. Considering the presently available monies, facilities and personnel, the loss of life, the disability and lack of accessibility to care can no longer be tolerated.

### **The Trauma Problem**

#### **Definition:**

The "critically injured" defines a patient who has sustained a life endangering injury. In addition, certain injuries such as severe eye damage, hand problems, massive facial lacerations, though not specifically life endangering, are critical in that they often result in considerable permanent disability. For this reason we include them in our definition of the critically injured.

This category of injuries accounts for approximately 10% of the emergency service problem. Listed below are certain aspects of this group of injuries:

1. These are the most serious problems within the emergency service situation.
2. The decision that an injury is critical can, in most cases, be made without sophisticated professional aid.
3. Extensive information gained from the treatment of battle casualties in Vietnam has not been utilized for civilian injuries in the community.
4. Criteria that are useful in establishing what is comprehensive emergency room care for ambulatory patients are not applicable to the accident victim with life endangering injuries.
5. In hospitals treating large numbers of trauma victims (e.g. Cook County Hospital), it has been shown that there are significant benefits in separating the critically injured from other ambulatory patients. Care can then be rendered in a specialized trauma-care unit.

6. From the professional, as well as the hospital point of view, the problem continues to grow because of complex sociological, geographic and economic factors not related to the technical and scientific advancements which can be utilized for treatment.

(a) The cost of caring for these patients is enormous. Besides reimbursement not meeting actual costs, one such critically injured patient can tie up equipment and personnel severely needed in other hospital areas.

(b) The disruption imposed on the hospital facilities is undeniable whenever these cases are not treated in specifically designated locations.

(c) Adding to the difficulties is the burden placed on the busy practicing physician. Often the patient is injured away from home and is cared for by someone other than his personal physician.

(d) When injured away from home, there is increased difficulty in gaining accessibility to medical help.

(e) There are also social problems which cannot be overlooked. The violence in the inner city, coupled with prejudices, both racial and economic, can create a problem in accessibility for many urban dwellers.

7. The consumer is demanding that action be taken to solve the problems associated with bringing modern medical knowledge to all members of the community.

#### **Background:**

Last year, the National Safety Council reported 11,100,000 injuries from all types of accidents.<sup>4</sup> Wage losses, medical expenses and administrative insurance costs resulting from trauma totaled \$13,600,000,000. The estimated total



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# A study of 150 accident deaths showed

cost of this pandemic is over twenty billion dollars annually.<sup>5,6</sup>

The National Safety Council estimates that 105,000 civilian accidental deaths occur annually; 47,000 are due to vehicle injuries.<sup>7</sup> The one-millionth traffic fatality occurred in 1951; if the present rate continues, the two-millionth victim will die by 1976.<sup>8</sup> Although our traffic injury problem is colossal, it is estimated that only 15% of the nation's accidents involve autos.<sup>9</sup> Accidents are currently the third commonest cause of death in the United States, being only slightly less than death from cardio-vascular disease and cancer.<sup>10</sup> Under 40 years of age, trauma is our leading cause of death. We are annually experiencing over 15,000,000 significant injuries of children under 14 years of age of which over 16,000 are fatal;<sup>8</sup> it is also the biggest killer in this age group with the peak incidence being from two to three years. One-third of all hospital admissions, approximately two million per year, are the result of accidents.<sup>12</sup> In one comprehensive study in a large metropolitan area, pediatric cases accounted for 47% of all emergency room visits and traumatic injuries stimulated one-fourth of these.<sup>11</sup>

The nationwide problems of emergency medical care delivery are well known. The intensive care and continued close surveillance which are necessary to maintain a critically ill patient are beyond the scope of the average practicing surgeon or physician. The average practitioner cannot devote the necessary time and involvement required for the long-term intensive management of these patients. Only where around-the-clock observation is available by hospital-based physicians, therefore, senior surgical and medical residents in training, can a high quality of medical care be continually available. Facilities with these personnel available are eager to receive and manage these difficult problems that are truly beyond the scope of one physician. At the present time, there are many competent medical personnel in the community who perform in an exemplary manner, especially in the acute resuscitation phase. These physicians, unfortunately, have no back-up, and are held responsible for complex problems that are beyond the ability of any one doctor. These patients must be evacuated after adequate resuscitation, which sometimes may even include major surgery, to better equipped and staffed facilities.

A solution to this complex problem will require the cooperation of many interest groups and resources. Of utmost importance in undertaking the project is continuous monitoring of the magnitude of the problem and the results which are obtained. With the use of special computer techniques, coupled with the only trauma registry in the United States, a comprehensive ongoing analysis of this major community health program will be possible.

## The Trauma Unit Concept:

As a solution to this problem, we are suggesting the development of an organized statewide system of specialized trauma units. A proposal for area-wide trauma units has been described for the city of Chicago by Freeark, and the Chicago Committee on Trauma.<sup>13</sup>

The trauma unit concept has proved to be an excellent plan for the in-hospital care of the critically injured. The plan of early physical segregation of these patients into a specialized area, staffed and equipped to completely resuscitate and evaluate the serious multiple injuries patient, can be adapted to hospitals of varying size and potential. The accumulative motivation, education and proficiency gained from many centers has been shown to be of great survival advantage in the early management of the critically injured (Fig. 1).

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### Trauma Unit Concept

Established geographic centers, with designated echelons of care  
Adequately staffed and equipped  
"Streamlined care" of the critically injured  
Part of General Hospital complex  
Communications and transportation  
Epidemiologic and clinical data collection

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Fig. 1.

A satisfactory outcome after severe traumatic injury is dependent on two basic factors: the availability of initial medical care, and the adequacy of these early therapeutic measures. A study by Frey, et al, in 150 accidental deaths showed that 18% could have been salvaged with better emergency service.<sup>14</sup> Delays in proper resuscitation and evaluation in life-endangering injuries are the crucial indices to survival. Injudicious or inadequate emergency management can cause unnecessary fatalities and permanent disabilities. The continually increasing incidence

## 8% could have been salvaged . . .

and magnitude of serious injuries resulting from high speed transportation, complex industrial equipment, continued civil disturbances, and unpredictable mass catastrophes, necessitates a re-evaluation and re-education of the priorities and techniques of trauma patient care. Changing patterns of traumatic injuries of all types and newer developments in the surgical subspecialties and biomedical disciplines have been responsible for major progress in the field of trauma management.

The first objective of the physician examining an injured person is the preservation of life. When dealing with acute trauma, it is impossible to separate diagnostic and therapeutic measures. The techniques of the resuscitation are not dependent on an etiologic diagnosis. Airway obstruction, shock and cardio-respiratory failure are similarly treated without knowing the precipitating causes of these disorders.

Once the patient is stabilized he may then be safely evaluated, treated or transported to a more competent facility.

### **Functioning Trauma Unit:**

The Trauma Unit of the Cook County Hospital in Chicago has had experience with over 28,000 seriously injured patients since its beginning in 1966. The Trauma Unit is a specialized facility, staffed and equipped to cope with all possible life-threatening emergencies. It is a centralized area where all of the essential hospital resources are concentrated for the comprehensive resuscitation, evaluation and operative needs of these patients. Principles employed in this specialized facility can be effectively utilized in any emergency room environment. We believe the trauma patient, because of the probable complexity and severity of his injuries, should be separated from other patients in any emergency room by streamlining his passage through the admitting and the X-ray departments into a special intensive care area. Close surveillance for the tell-tale signs of shock, aspiration, respiratory distress, and cardiopulmonary arrest can avoid possible catastrophe. Should such untoward effects develop, adequately trained physicians, nurses and paramedical personnel are readily available to institute effective therapy.

### **The Trauma Registry:**

The complexities involved in the various as-

pects of severe injuries in conjunction with the deficiencies in our health care delivery system have thus far precluded comprehensive quantitative analysis. With the introduction of modern computer technology, it is now possible to thoroughly investigate the epidemiological and clinical aspects of this major health problem.

A computerized trauma registry has been developed at the Trauma Unit of the Cook County Hospital and Research Resources Laboratory of the University of Illinois. It uses an IBM 360/44 Computer and a generalized information retrieval system. The registry employs a card-oriented data collection procedure, but will soon be utilizing direct entry from remote dataphone terminals. This means that any participating facility can address information into the computer. The internal classification of disease categories (adapted 1969) are integrated in the registry, but a new tabulation system is being utilized as the prime patient indexing method.

For the first time, a multifactorial approach to this complex major community health problem is possible. The registry will be instrumental in analyzing mortality rates for graded injuries in paired patients comparative studies, and determining risk factors for various accidental events. The computer cost for such services is far below typical record library expenses.

As information is collected on epidemiological factors, extent of anatomic damage, operative treatment employed, and specific complications, the program will not only be formulating solutions but initiating feedback based on fact rather than intuition.

### **Critically Injured Patient Problem:**

National symposia, as well as numerous local workshops have been concerned with this problem. Personal experience and anecdotal analysis do not, however, provide the basis for sound operational approach to this dilemma. The president's address at the American Association for the Surgery of Trauma and the Schudder oration on trauma at the American College of Surgeon's Clinical Congress<sup>15</sup> were directed to these problem areas. Both speakers, at some length, discussed the many self-appointed and multi-directed groups that are presently involved with some small aspect of emergency medical care. There is presently no central or organizational agency involved with the analysis, planning and



# "The most difficult problem — coordination

development of a local or statewide program.

## Conclusions:

We believe that a statewide organization of trauma units as an approach to the critically injured may provide a working solution upon which to solve many of the deficiencies in emergency medical care in this state. We also believe the trauma unit concept, if instituted in a statewide comprehensive program, cannot only give Illinois a working life-saving system, but also a model for the nation to utilize.

### A Model for Emergency Care of the Critically Injured Patient

#### An overview:

The basic concept of this plan is to coordinate the existing hospital facilities in conjunction with the available manpower and add essential equipment as necessary. At present, in Illinois there is no organized plan either on the part of the hospitals or the medical profession for the treatment of critically injured persons, individually or as part of a civilian disaster. Compounding the situation is a public totally unaware of the facilities available and of the medical potential in the community.

The proposed model has three functioning levels to solve these problems. The basic unit is the emergency room of a community hospital, and if present, its intensive care unit. It functions as the immediate provider of care. Attached to its emergency room is a specialized ambulance of the type recommended by the American College of Surgeons.<sup>16</sup> According to Senate Bill 568, this unit is a Type B emergency room, one that is fully equipped, providing 24-hour service and has a physician on duty at all times.

Servicing many local basic units is the area-wide trauma center. This is a hospital with a house staff, teaching programs, specialized treatment units, and many specialty services not available at the local level.

Finally, there will be a small number of university-based regional trauma centers where the full advantages of modern science can be utilized for the care of patients whose condition warrants intensive diagnosis and therapy. One of the centers will act as the coordinator and administrator of the proposed state program.

#### The local hospital unit:

This is a hospital which fulfills the following criteria. Although many criteria are consistent with Senate Bill 568, this program requires more stringent organization and trained personnel (Fig. 2).

1. There is twenty-four-hour medical and paramedical coverage which can provide comprehensive emergency care to a critically injured patient. Personnel are available to make diagnoses and institute basic resuscitation and treatment necessary to sustain life and to make the decision to continue therapy within its own confines or referral by helicopter to the areawide center will be made.

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#### Local Area Trauma Center

Serve a specified geographic area (50 miles)  
Maintain a Type "B" emergency room service (S.B. 568)  
24 hour Medical and Paramedical Coverage  
Comprehensive Resuscitation and Specialty Care Potential  
Staff trauma coordinator  
Hospital based ambulance (American College of Surgeons, Recommended Model)  
Radiocommunications system  
Dataphone Remote Terminal

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Fig. 2.

2. It must have competent emergency facilities which will not require large sums of money for the addition of essential equipment.
3. A desire on the part of the hospital and professional staff to offer emergency care to an area which includes an ambulance round-trip of no more than two hours (i.e. approximately a 50 mile radius). In urban areas, this would by necessity be a much smaller distance and, in many cases, might be no more than one or two miles.
4. There must be a specific location within the hospital, set aside and designated for the care of trauma victims with necessary equipment, medication, and most important, the personnel.
5. The type of personnel will vary with the specific hospital. The following is a minimum suggested staff:
  - (a) A staff physician to act as the local trauma coordinator. In small communities,

# local community's resources into one "

this physician may be the only doctor with trauma training, while in others, he may be the senior staff surgeon. In any case, it is his responsibility to see that the program functions properly. It does not imply that he is the physician in charge of all patients, the only referring doctor, or even responsible for medical care at all times. His duties encompass keeping the facilities functioning, the program vitalized, the paramedical personnel trained, and the program data collected and transmitted to the central computer.

(b) At his disposal is at least one paramedical, trained individual who is available at all times to assist him.

6. A hospital-based ambulance of the type specified by the American College of Surgeons. This ambulance, which is equipped to handle an injured person at the scene of the accident, is manned by individuals with training in the care of severely injured. The criteria for this training has been detailed by the American College of Surgeons. The key to the program is the education of the personnel involved at all levels of the system.
7. There are two significant aspects regarding paramedical personnel. First, there must be an immediate upgrading in the level of care afforded at the site of injury by ambulance personnel. Second, the initial care provided by the professional staff at the designated local trauma unit. Central to the theme of this program is the desire to utilize, wherever possible, the present staff properly trained in the care of the severely injured. Where applicable, personnel can be retrained through grants, so that at least one individual trained in trauma is available to provide 24-hour consultation coverage.
8. A coordinated system of communications between ambulance, hospital, and the area-wide center.

The most difficult problem is not how to create this local emergency care facility, with its specialized personnel and equipment, but how to pool and coordinate the local community's resources into one. This means reorganization through voluntary action among many local hospitals in some communities, and in others, some

arbitrary choice between two duplicating and inefficient emergency rooms, sometimes very closely situated.

## The areawide hospital center:

This institution must have an accredited teaching program in surgery, though university affiliation is not required. This facility will be the referral center for a number of basic trauma units. As the center for local units, it will provide four vital functions (Fig. 3):

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### Areawide Hospital Trauma Center

**Serve a local and areawide geographic district**  
**Maintain a Type "A" emergency room service (S.B. 568)**  
**Clinical Training Programs**  
**Provide Standard and Specialized Functions**  
**Trauma and specialty professional staffing**  
**Hospital based ambulance and helicopter service**  
**Radiocommunications Center**  
**Data Collection Unit**

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Fig. 3.

1. Provide service to the local community in which it is situated by functioning as a Type B unit.
2. A communication center which will give medical and technical advice to the local hospital trauma center.
3. A helicopter service. Any patients, whose injuries or status requires more sophisticated care, either because the problem cannot be handled at the local level or the facilities are not available, will be flown to one of a dozen or so designated areawide centers. The service must be available on no more than a four-hour basis (300 miles). At present, approximately 40 hospitals in Illinois have heliports which are not utilized.
4. Special care units for the treatment of trauma victims, providing sophisticated study, treatment and equipment, complemented by the full range of medical specialties. These would include blood banks, training centers, special laboratories, hemodialysis facilities, etc.
5. Meet all the criteria for a comprehensive unit as Type A set forth in Senate Bill 568.

## The regional center:

Since these centers will function as the regional planning and coordinating hubs, they should be



# Senate Bill 568 allows a group of hospitals

responsible for financial disbursement, training and educating professional and non-professional workers at all levels, have super specialty facilities (burn units, transplant facilities, hyperbaric chambers, etc.), they must, by dint of available manpower and facilities, be located in the university medical centers throughout the state. At present, this means six in Chicago and the proposed centers at Springfield, Carbondale, Rockford and Peoria (Fig. 4).

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## Regional Trauma Center

Serve a local, areawide and regional geographic district  
Maintain a Type "A" emergency room service (S.B. 568)  
General and Subspecialty Training Programs  
Provide Standard and Special Investigational Functions  
University hospital staffing  
Hospital based helicopters and ambulance services  
Communications Center  
Central Trauma Registry

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Fig. 4.

These centers at the same time would also provide basic facilities to their local neighborhoods.

Since the manpower and facilities for care are now available at this level, the only difficulties are those of organization and administration. These centers, with their training programs and facilities, will in most cases, be delighted to assume the job.

The regional center will be tied by radio and dataphone communications to its many member areawide institutions. The helicopter service based at the areawide hospitals would serve as its transportation arm.

There is no intention to have routine cases forwarded to the regional center. The vast majority of cases would be handled at the areawide level—Type A. In some areas most of the routine work can be accomplished at the local level—Type B.

### The problem in the Cook County area:

This model is not applicable to the Cook County area without specific modifications. There are a number of specifics to the Chicago-wide area which must be considered. Many of these problems are detailed in the emergency service report from the University of Chicago.

1. A police policy which requires that patients

be brought to the nearest hospital emergency room.

2. A large indigent population, without easy access to medical care, geographically isolated, where trauma is mostly secondary to human violence rather than accidents.
3. Six medical schools, of which five have their own medical centers.
4. Non-university affiliated medical centers.
5. A long history of inability to solve problems by cooperative organization because of petty jealousies, both administrative and medical in content.

On the other hand, many of these so-called difficulties, if properly coordinated, can be turned into advantages. In the Chicago area, an abundance of facilities and trained manpower is presently available. Very little in the way of money, new personnel or funding is necessary, but rather a willingness to accept a plan of action by the member hospitals and medical staffs.

The problem created by the requirement that injured persons be taken to the nearest emergency room, which in the past has been a major obstacle to comprehensive planning, has been relieved by Senate Bill 568. This law allows a group of hospitals to designate levels of emergency room care. Thus, the police can take seriously traumatized patients to the nearest designated emergency room.

In Cook County, most participating hospitals will function as areawide Type A comprehensive emergency treatment centers. Since many of them have well-equipped emergency rooms and trained personnel, they will handle most non-critical injuries. The small Type B and C standby and basic hospital emergency rooms can be designated as emergency rooms for ambulatory trauma patients. The critically injured patients will be sent directly to the regional hospitals.

The areawide, Type B, hospitals will be divided into regions, each relating to one of the six medical centers. The medical centers, as in the rest of the state, will be responsible for data collection, financial responsibility, and training as described in previous sections. However, in the urban program, they will be charged with the care of all critically injured persons and, whenever possible, these patients will be brought directly to their trauma centers.

It is anticipated that certain hospitals will not

# to designate levels of emergency room care

desire entry into this plan. It must be emphasized that the program is voluntary, and it is hoped that as the plan proves successful, institutions at all levels will seek admission.

## Development of the Program

At the present time, there are numerous agencies studying the emergency medical care problem. Each of these agencies and commissions are groups attempting to define some chosen aspect of the problem. At the completion of these necessarily limited studies there has been no central or authoritative forum where their findings can be presented.

A very real problem is the implementation of such a broad-based program. The development of any major reorganization scheme and the concomitant distribution of medical resources, will unfortunately, meet with resistance to change. However, by working with the medical societies, the hospitals, and most importantly, the physician in the field, an honest aggressive sales pitch should return the necessary cooperation and support. Support will be obtained by showing these groups that the basis of our plan is to involve the physician and his local hospital and staff with the responsibility for the primary treatment and transfer decisions. To carry out these tasks they will be given the necessary essential modern equipment. An ongoing education extension program is envisioned to continually update professional and paramedical personnel.

The entire emergency health care delivery program will be possible only through the auspices of the local county medical societies, and specialty organizations, such as the Committee on Trauma of the American College of Surgeons.

## Illustrations

### The present system:

A youthful 31-year-old mother of two, driving along an Illinois highway, is involved in an automobile accident. Her car, skidding on a patch of ice, careens off the road and hits a telephone pole. She is knocked unconscious with head injuries, and associated abdominal and extremity damage. It is one hour before the State Police find her wrecked auto. The nearest town is 25 miles away and the police request an ambulance.

Because of the late hour and lack of any plan or organization to treat accident victims, it takes another 90 minutes before the victim finally reaches a small community hospital with a standby emergency room. There is a nurse on duty but she has no formal trauma training, and another two hours elapse before a physician arrives to render care.

The victim, though requiring intravenous fluids, chest tubes, care of a fractured leg and other immediate therapy, receives only basic first-aid treatment. Through no fault of the medical personnel in attendance, the proper equipment is not available, nor if available, can it be mobilized.

It takes another five hours before the proper personnel can be mobilized to perform surgery. The patient's condition is followed during the next few days by a limited staff already overworked with other medical problems and duties.

Again, the patient's condition deteriorates. This time because the magnitude of her injuries has caused slowly progressive head and kidney damage. There is another delay of three days before these complications are noticed because of the shortage of personnel and lack of specialized detection equipment.

As often happens, the attending physician decides that this patient should be referred to an institution capable of dealing with a problem of this magnitude. It may very well be that he is fully trained in the care of trauma, but without support, there is very little that can be accomplished.

It takes another 48 hours before arrangements can be made to transfer this patient to another hospital some 175 miles away. The trip takes four hours by ambulance during which time the patient's condition steadily declines. Finally, reaching a 250 bed hospital which has a multitude of specialists, and the necessary equipment, little can be offered because of the delay; and the patient expires three days later.

All of the individuals involved, from the state highway patrolman, to the neurosurgeon performing the last ditch, life-saving operation, are filled with remorse. They feel that everyone did all that was possible. In fact, it may be another year before another accident of that type occurs in the community and by that time the tragedy will have all but been forgotten.

However, if one accumulates these individual



# The basic geographic regionalization .

accidents on a statewide basis, the overall loss of life, prolongation of hospital stay, and extensiveness of individual disability becomes frightening in scope and magnitude.

## The future program:

What occurred in the previous example should not have happened. The State Police would call the nearest hospital with a Type B trauma emergency room. In our previous example, instead of the patient going to the unprepared hospital, she might have gone in the opposite direction to a hospital of 250 beds with a fully staffed trauma facility. The unit is notified before the patient arrives and a pre-planned program is instituted. Minutes after the patient is examined in the emergency room it becomes apparent that the problem is complex and will require many specialists having available a full range of paramedical services.

The areawide center is notified about an impending transfer. At the same time, advice is offered regarding the latest treatment for severe head injuries.

The local physician requests that helicopter service be initiated. With the help of the paramedical team the patient is stabilized and therapy instituted. It takes three hours before the accident victim arrives at the regional center. The most sophisticated treatment available is utilized in treating the victim, and during the next few days she remains under 24-hour care because of the presence of a house staff. She undergoes two major surgical procedures. During her recovery period, which spans a period of four weeks, the professional staff works with the knowledge that a university center with specialized services is ready to back them should the need arise.

## Conclusion

Contrasting the two brief examples above, it is obvious that there is no new facility or expensive cost requirement. All that must be accomplished is organization of a system that presently exists in a fragmented form.

Consider the following:

1. The patient's insurance covers many of the medical costs; whenever hospital stay is diminished, a substantial insurance savings results.
2. Choice of referral will remain with the responsible physician.
3. Whatever initial costs are incurred in organizing the program will be quickly offset by the economic savings accumulated by decreasing losses in life, loss of work time, diminution in permanent injury and the fuller utilization of existing facilities.
4. The accumulation of scientific data, coupled with improved training and education of personnel at all levels.
5. The first statewide system in the United States which can bring to its citizens the full impact of medical care that has been learned from the treatment of battle casualties from Vietnam.
6. A statewide system to be used as the framework for a civil defense plan in time of disaster.

The tangible return of comprehensive and integrated emergency care system will have to be evaluated. Monitoring of time and morbidity factors will be made possible by the use of the Trauma Registry and can document the advantages. The ability to organize volunteer help and community financial support for ambulance service and emergency care costs may be an indication of the productiveness of this plan. The citizen's awareness that he will have an equal opportunity to receive optimal emergency medical care when it is most needed will result in considerable community enthusiasm and support.

These programs will entice previously trained personnel, as well as future aspirants into the health care system. Specific aim will be made at the medical corpsman who have been extremely well-trained by the federal government to remain in the health-care delivery system. The program, as it is developed, will enhance the performance of professional and paraprofessionals at all levels.

At the present time there is a great deal of duplication in medical research. In any major institution, one or more investigators may be involved with very similar and related research interests. The awarding of grants in many instances is not well-planned. While competition is good, duplications of expenditures for personnel and equipment can no longer be tolerated. A central agency could best allocate or advise

an have wide application . . .

in the distribution of monies in the best interest of the public needs. Also, with new computer methodology, a combined inter-disciplinary study coupled with institutional multiple approach can be developed for the benefit of all.

As the problem of the critically injured patient is solved, new ways will be developed to evaluate and manage other urgent medical problems. The basic geographic regionalization, if utilized successfully, can have wide application in the solution of many health care problems. ◀

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## Spinal meningitis vaccine tested

A vaccine against the organism which causes spinal meningitis may be ready for field trials soon, according to the National Society for Medical Research.

Human trials, backed by successful laboratory animal data on rats, mice and rabbits at the Massachusetts State Biological Laboratories, has enabled the new vaccine to pass safety tests of the Division of Biologics Standards.

"Approximately 27,000 children contract the dreaded disease annually in this country, as a result of the *H. influenzae b* organism which causes it. About 30% of the children suffer long-term disability as a result of the disease, and 2,000 reportedly die."

The vaccine was developed at Harvard Medical School. Dr. David Smith, associate professor of pediatrics at Harvard, said that spinal meningitis is one of the most serious of childhood infections.



# Ischemic colitis

## a case report

BY RAMASWAMAIAH CHANDRASEKHARA, M.D. AND RUVEN LEVITAN, M.D./CHICAGO

Ischemic colitis, confined to the rectosigmoid area alone, is not a widely recognized syndrome, while ischemic colitis of the other parts of the colon is now known to the medical profession.<sup>1</sup> The following is a case report of ischemic colitis limited to the rectosigmoid colon. The diagnosis was made by sigmoidoscopy and later confirmed by biopsy, barium enema, and selective angiography. Subsequent follow-up barium and proctoscopic studies demonstrated the transition from ischemia to stricture at the rectosigmoid junction. This patient emphasizes the fact that ischemic colitis should be considered in the differential diagnosis of diarrhea, rectal bleeding, and sigmoidal stricture in the aged.

### Case report

A 76-year-old male was admitted to the Veterans Administration West Side Hospital on August 26, 1969, with a history of melena. He was known to have chronic arteriosclerotic brain syndrome and arteriosclerotic heart disease since July, 1969.

On admission he was not in acute distress but was confused and emotionally labile. Blood pressure was 110/70 mm Hg, pulse 82/min. irregular, and temperature 99.8° F. Heart sounds were

normal. A grade II/VI ejection systolic murmur was heard over the left sternal border. Tenderness over the umbilical and suprapubic region was elicited. Bowel sounds were hypoactive. On rectal examination, the sphincter tone was diminished and the stool was liquid mixed with bright red blood. The hemoglobin was 16.2 gm%, hematocrit 48%, and the leucocyte count 12,400 with a shift to the left. The EKG showed premature beats and an old combined myocardial infarction. Proctoscopy revealed a normal mucosa up to 15 cm; from there up to 25 cm

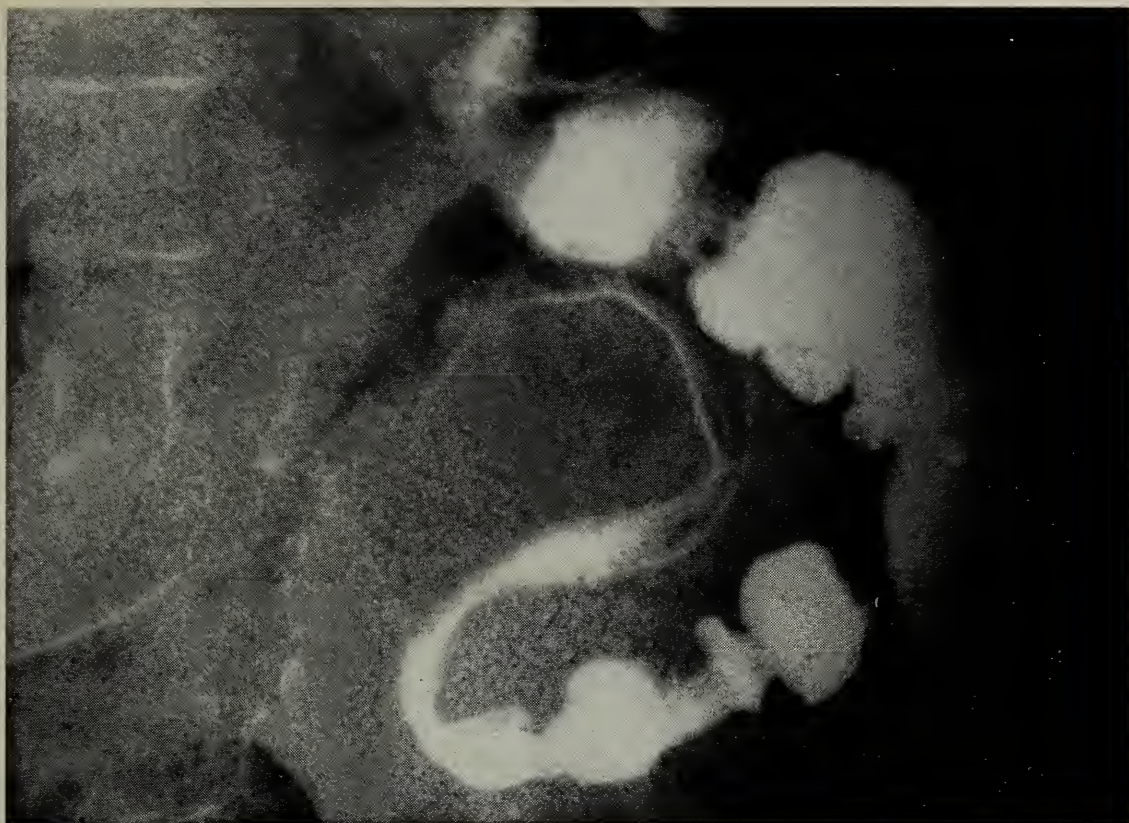


RAMASWAMAIAH CHANDRASEKHARA, M.D., (right) is a resident in internal medicine at The Abraham Lincoln School of Medicine, University of Illinois. He served his internship at K. R. Hospital, Mysore University and MacNeal Memorial Hospital in Berwyn.

RUVEN LEVITAN, M.D., F.A.C.P., (left) is chief of the Gastroenterology Section at the Veterans Administration West Side Hospital, and professor of medicine at The Abraham Lincoln School of Medicine, University of Illinois. He received his M.D. from the Hebrew University, Hadassah Medical School and had training at Massachusetts Memorial Hospital, Boston, in gastroenterology. Dr. Levitan is certified by the American Board of Internal Medicine and Gastroenterology.



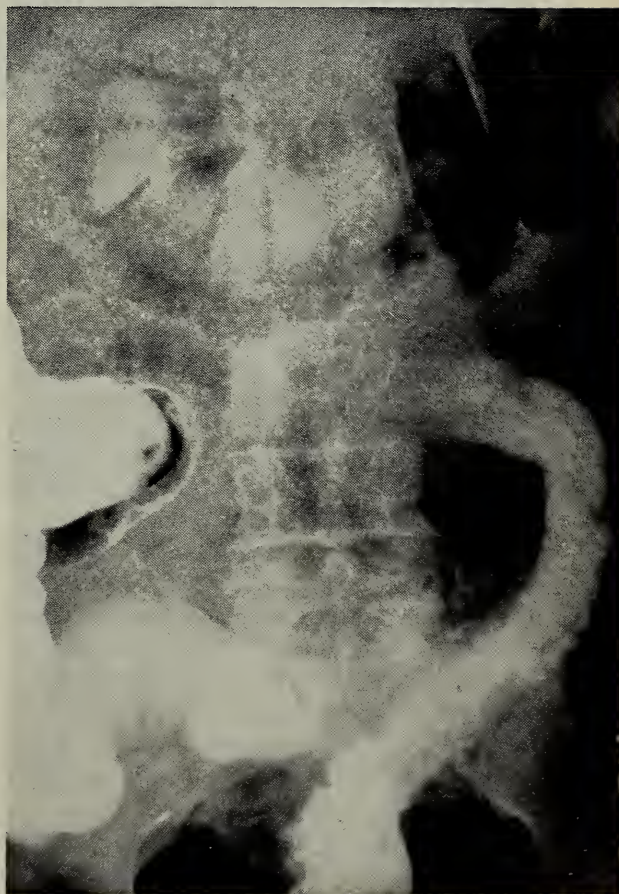




**Fig. 1. Barium enema on admission, showing scalloping and rigidity.**

the mucosa appeared edematous, purplish, friable, and the wall was rigid. A biopsy was taken from that region and no bleeding was observed. Microscopically, the mucosa was entirely necrotic, hemorrhagic, and contained numerous bacteria; no normal tissue was seen. A barium enema revealed marked swelling of the mucosa of the sigmoid loop with some scalloping and limited rigidity (Figs. 1 & 2). A selective angiogram showed that the inferior mesenteric artery was completely occluded. The patient did well clinically on symptomatic treatment.

A repeat proctoscopy, 14 days after admission, showed that the mucosa in the involved bowel was now pink, granular and friable. The proctoscope could not be advanced beyond 19 cm. A biopsy taken at 15 cm revealed only mild chronic inflammation. A barium enema, when the patient was asymptomatic, demonstrated a narrowed stenotic loop of the sigmoid colon just beyond the rectosigmoid junction (Fig. 3). A second barium enema showed evidence of the previous stricture. The rest of the colon appeared unremarkable.



**Fig. 2. Barium enema on admission, showing scalloping.**

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*Supported by Research Grant AM 13387 from the National Institute of Arthritis and Metabolic Diseases and the Veterans Administration Medical Research Funds.*



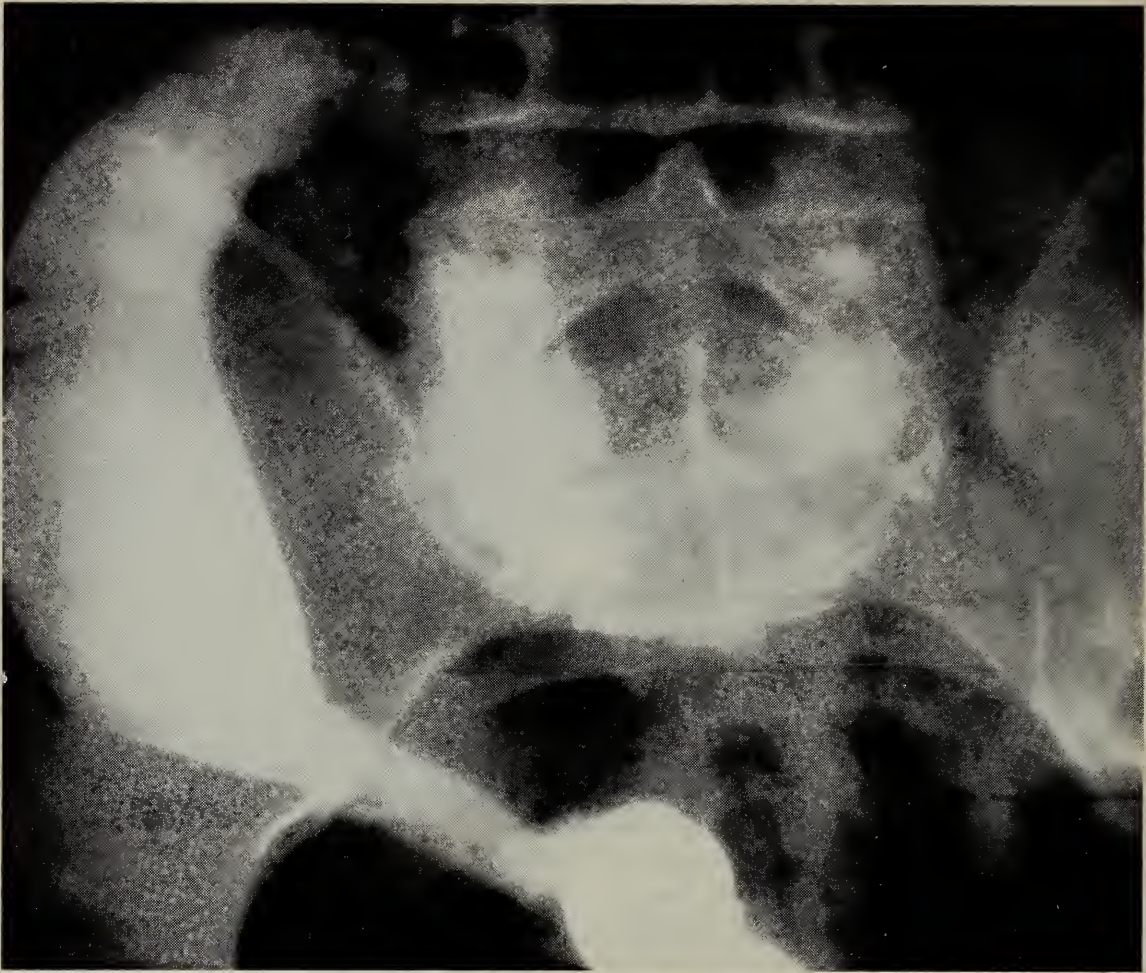


Fig. 3. Barium enema demonstrating the stricture just beyond the rectosigmoid junction.

### Comments

The inferior mesenteric artery is frequently cut by vascular surgeons during repair of aortic aneurysms with impunity, but occasionally this procedure leads to the complication of ischemic colitis.<sup>2</sup> The interruption of the inferior mesenteric artery is tolerated because of the marginal artery of Drummond which supplies the descending colon via collaterals. However, when the marginal artery is occluded or congenitally absent (five per cent), blood supply to the splenic flexure and descending colon is compromised and ischemia results<sup>2,3</sup> after interruption or occlusion of the inferior mesenteric artery. This sequence of events has also been demonstrated experimentally in dogs by Marcuson et al.<sup>4</sup> It may be complicated by gangrene of the colon, shock, perforation, infection, and stricture formation.<sup>3-5</sup>

Our patient did not complain about any symptoms presumably because of his mental status. Though hemorrhagic infarction of his sigmoid

colon resulted initially, the collateral circulation was evidently adequate to allow recovery. We were able to make the diagnosis of ischemic colitis by sigmoidoscopy and biopsy as has been the experience of the other authors.<sup>5-7</sup> However, if the patient had presented himself to us two to three weeks later, a barium enema could have been readily interpreted as granulomatous colitis. Several months later, the stricture would have been interpreted as carcinoma of the colon.

As our geriatric group of patients increases in numbers, ischemic colitis will become an important entity which should be considered in the differential diagnosis of diarrhea, rectal bleeding and colonic stricture. Early diagnosis and prompt attention to complications will hopefully reduce the morbidity and mortality of ischemic colitis and avoid unnecessary surgery in the aged. These considerations become even more crucial in the institutionalized patients who are unable to relate their symptoms clearly. ◀

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## *Accidental poisoning victims . . . a thing of the past*



*Child  
Resistant  
Containers  
are here!*

BY DAVID R. SILVESTRI, DIRECTOR OF PUBLIC RELATIONS,  
WEST SUBURBAN HOSPITAL/OAK PARK

Each year almost 80,000 children in this country, under five years of age, become accidental poison victims after swallowing medicines or other products not meant for them. Of this total, over 40,000 of the deaths were attributed to medicines. A simple two cent item, called a *CRC*, *Child Resistant Container*, could have kept 90% of these children from getting into the bottles, whose contents proved fatal.

Only one major drugstore chain and a manufacturer of children's aspirins have bothered to use the *CRCs*. However, change is in sight due to the persistent efforts of an Oak

Park couple and members of the West Suburban Hospital medical staff.

On October 9, 1970, two-year-old Leslie Waichler was rushed to West Suburban Hospital after she had accidentally swallowed 20 tablets. For six hours, doctors and nurses worked to save her life, and went so far as to perform a complete blood transfer. Leslie died the following day.

A few weeks later, her parents, Mr. and Mrs. Dick Waichler, mailed 3,000 letters to friends, asking them to support the passage of Senate Bill 2162, the "Poison Prevention Packaging Act of 1970." One

of the letters was sent to Dr. Harold A. Sofield, a member of the West Suburban Hospital staff and the Board of Trustees. Dr. Sofield, an Illinois delegate to the American Medical Association, arranged to have the Senate bill presented to the AMA's House of Delegates at their meeting in Boston, in December in a resolution calling for passage of the Bill.

The AMA House of Delegates unanimously passed Dr. Sofield's resolution, calling for the adoption of the bill, requiring *Child Resistant Containers* for all medicines, except in those instances where a handicapped individual might have difficulty in opening such containers. In these cases, the physician would note this on the prescription.

The "Poison Prevention Packaging Act of 1970"—Senate Bill 2162—through the efforts of individuals like Mr. and Mrs. Waichler, Dr. Harold A. Sofield, and the AMA's House of Delegates was signed into law by President Nixon.



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He understands your concern about insuring your family's welfare. After all, he's a family man, too.

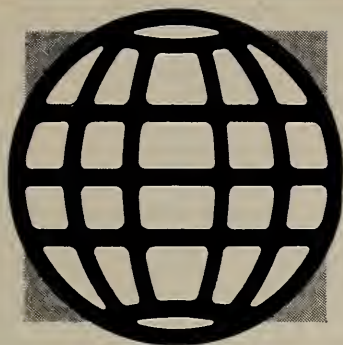
Why not check with your lawyer and call Dan Wegner at (312) 732-4301. He can free you from worry.



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First National Bank  
of Chicago**

Personal Trust Service





# socio-economic news

a service of the division of health care delivery

By JOSEPH J. LOTHARIUS

## Seek plan to implement FMC concept in State

Special ISMS consultants listened to opinions from physicians and executives of nine county medical societies and discussed with them the possibilities of establishing a Foundation for Medical Care in Illinois. The consultants, representing the United Foundations for Medical Care and Uni-Med Services, met with the key leaders of the local medical societies March 1-5.

The week-long series of discussions will help the consultants and ISMS's Health Care Financing Committee arrive at a practical and acceptable state-wide approach to the FMC concept. The recommendations made by the consultants will be presented to the ISMS Board of Trustees and House of Delegates for final approval.

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## Medicare updates fee profiles

Medicare fee increases have been authorized by HEW that will recognize physicians' 1969 fee profiles. The fee profile updating, effective January 1, 1971, was announced by Continental Casualty Company and Blue Shield, the two Illinois Medicare (Part B) carriers. It was pointed out, however, the profile updating would be applicable to only those physicians who had increased their fees in 1969, and had been billing at the higher rate since that time. The physicians' charges must also correspond to the usual and prevailing (customary) fees of the area.

\*\*\*\*\*

## 75th & 83rd percentiles may be The same

HEW combined its announcement authorizing fee profile updating with the news the Department was lowering the cut-off or ceiling on physician services from the 83rd to the 75th percentile basis. Computer experts at Continental Casualty Co. say, however, this lowered ceiling does not necessarily mean that the previously announced fee increases would be cancelled. According to Continental, the 83rd percentile used prior to January 1, referred to what 83% of the physicians charged for a similar service in a given area. The apparent reduction to the 75th percentile is not necessarily a reduction at all, says Continental, *because it refers to 75% of the services performed by all physicians in a given area.*



The cut-off or ceiling is determined by the 75th percentile of the total number of services rendered by physicians. Continental also told ISMS that if the new method of computing charges resulted in a rate less than the previously used 1968 levels, the higher allowance would be used.

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#### **Most MDs favor DVR program**

All but two of the 35 county medical societies responding to an ISMS questionnaire on the Department of Vocational Rehabilitation considered DVR to be a worthwhile program. Other interesting answers revealed physicians in 26 of the 35 counties felt reimbursement from DVR was adequate: 15 felt the DVR program was being abused, and 15 thought DVR eligibility guidelines were inadequate. Suggestions most commonly made by local physicians for improving the DVR program included: DVR Councilors should provide physicians with more detailed information when asking for examinations on potential DVR recipients; Department Councilors should use better judgement in recommending students to DVR; better communication between the Department and medical societies especially regarding eligibility guidelines; and requests for DVR to update its fee profiles.

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#### **DVR to extend limits Of payment**

DVR has proposed extending its limits of payment to reach the usual fees of at least 70% of Illinois physicians. In a letter from Mr. Alfred Slicer, DVR director, to ISMS' Advisory Committee to DVR, Mr. Slicer says: "We feel this plan will be even more satisfactory to a greater majority of physicians, and that it is attainable unless more serious budget cuts occur in the next year from federal and state sources."

Mr. Slicer said if ISMS concurs with the proposal and when it is approved by the Illinois Bureau of the Budget, it would be implemented immediately.

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## ***Medical education self-test Offered at Convention***

How does your medical knowledge stack-up to that of your colleagues?

By visiting the medical education self-testing area, adjacent to the scientific exhibits, at the ISMS annual meeting, May 17-19, at the Arlington Park Towers Hotel, you can uncover any gaps which might exist in your medical knowledge.

The self-test will enable you to determine your own educational needs by comparing your knowledge with the "average" performance of your colleagues. All test results are confidential.

Test materials will include actual models, audio-visual aids, printed clinical simulations and computerized clinical problems. The program was developed by the Illinois Regional Medical Program in cooperation with the University of Illinois Center for Educational Development.



## medical legal review

### *Abortion: The legal ramifications*

BY FRANK M. PFEIFER, ISMS LEGAL COUNSELOR/SPRINGFIELD

The following is an explanation of the legal ramifications of the recent decision on abortion.

"On Jan. 29, 1971, a three-judge Federal District Court in Chicago handed down a decision holding that the Illinois abortion law violated the Constitution of the United States. The Court stated that abortions could be performed at the request of the woman so long as the pregnancy has not exceeded three months and the abortion was performed in a licensed hospital by a licensed physician. The Court issued an injunction restraining the state of Illinois from prosecuting physicians for performing abortions if the conditions listed above were met.

"An appeal of this decision is being taken to the United States Supreme Court and this Court also has been petitioned to issue a stay order which—if issued—would hold the lower court decision in abeyance until a final decision by the U.S. Supreme Court.

"Under the law as it now stands (since the decision January 29, 1971) physicians may legally perform abortions in licensed hospitals if the pregnancy has not exceeded three months unless and until a stay order is issued by the Supreme Court. If the stay order is issued, the law would refer to that in existence prior to the decision, namely that an abortion can be performed only if necessary to save the life of the woman.

"Physicians still may refuse to perform abortions and hospitals, likewise, may refuse to permit such a procedure within the institution.

*"It is suggested that all concerned proceed with caution until the U.S. Supreme Court has decided this question because—if the operation is performed after a stay order has been issued—the operating physician would be in violation of the Illinois law which could carry up to a 10-year penitentiary sentence."*

The Illinois State Medical Society's current policy on abortion was determined by its 1969 House of Delegates. That policy, which remains in effect until changed by the House, is as follows.

"RESOLVED, That the Illinois State Medical Society is opposed to induced abortion except when under the following conditions:

- I. There exists documentation of a severe threat to the health or life of the mother, or
- II. There is documented medical evidence that the conceptus may be born with incapacitating physical or mental abnormality, or
- III. There is documented evidence that continuation of a pregnancy resulting from statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient, and
- IV. Two other physicians chosen because of their recognized professional competence have examined the patient and concurred in writing, and
- V. The procedure is performed in a hospital legally licensed and approved by the State of Illinois for the care of maternity patients."

*NOTE: Mr. Justice Marshall, one of the Judges of the U.S. Supreme Court, issued a stay order on February 10, 1971, which holds in abeyance the decision and injunction issued by the three judge Federal District Court on January 29, 1971.*

*Frank M. Pfeifer advises that the state order returns the abortion law in Illinois to its status before the decision in January; namely that the performing of an abortion is illegal unless necessary for the preservation of the woman's life.*





## practice management

### *Delegation of paramedical duties— How does your office rate?*

BY ROBERT P. REVENAUGH/PROFESSIONAL BUSINESS MANAGEMENT

A physician today must not only be a professional man to his patients but also a business executive. As a business executive, he must divorce himself from as many routine nonmedical or paramedical jobs as possible. We know of practitioners with practice receipts totaling \$35,000 per year and other practitioners in similar circumstances grossing approximately \$100,000 per year. This difference in productivity is not necessarily the result of greater effort. One of the greatest differences is a doctor's ability to organize the business side of his practice, and likewise, to delegate as many nonmedical and paramedical functions as possible.

Presume the average doctor will gross over \$20 per hour worked. If he can hire an aid for \$2.50 per hour and if the aid can do in eight hours what he can do in one hour, the doctor has broken even. Nonmedical functions, such as clerical jobs, can probably be done by an aide more efficiently than by a doctor. As an example, by being relieved of these responsibilities one hour per day, a physician could see more patients, which would be in the community's interest and could also increase his income by approximately \$7500 per year. He could thereby enjoy a greater ease of practice.

The amount of time taken by the doctor to

perform these nonmedical duties is seemingly insignificant if one considers only each instance. But if one projects the loss of three minutes for each of thirty patients seen per day, the loss of productive time is significant; about one and one-half hours per day or 36 work days per year. Obviously insignificant minutes can compound into considerable productive time loss. A doctor might profitably review his office routines with an eye toward eliminating these less productive minutes.

Some of the nonmedical functions which the doctor might delegate are shown below. Which of these duties are nonmedical and which constitute the practice of medicine is beyond the scope of this article. However, as a prerequisite to an effective delegation of duties, the aides must be capable, carefully trained, and properly supervised.

At present the average doctor employs 2.8 girls. It has been estimated that by 1975, 4.1 girls will be employed per doctor. The doctor shortage and the growing volume of paper work will make delegation of paramedical and non-medical duties of increasingly greater importance to the efficient practice of medicine. What are you doing today that might properly be delegated to a capable aide?

The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

#### How anxiety may interfere

In many cases the mere apprehension that return to work might shorten life prevents the patient from resuming activities. It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases,<sup>1</sup> and Thomas<sup>2</sup> suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

#### As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl) :

- ☐ Quickly relieves anxiety of mild to severe degree in most cases
- ☐ May help patient to follow therapeutic regimen
- ☐ Is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents
- ☐ Helps encourage productive activities by relieving anxiety
- ☐ Is suitable for extended therapy, usually without need for increase in dosage; periodic blood counts and liver function tests are advisable.

#### References;

1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967.
2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

To curb moderate to severe anxiety in the postcoronary patient adjunctive

**Librium® 10mg**  
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1 or 2 capsules  
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## **"Birthright" group offers solutions to problem pregnancies**

Birthright of Chicago is a private, non-sectarian organization and an outgrowth of an idea begun in 1968, in Toronto, Canada, by Mrs. Louise Summerhill. Similar crisis centers for pregnancy have since spread over North America to include Vancouver, Denver, Cleveland, Minneapolis and other cities.

The method of operation in each city is similar. A well-advertised telephone number is answered by a Birthright volunteer, who has been trained to listen with sympathy and complete unshockability, and assist the pregnant woman in finding a maternity home, medical care, legal, and financial assistance, adoption guidance or other needed help. *The principal purpose is to find alternatives to abortion as a solution to problem pregnancy.*

The telephone number in Chicago is 233-0305.

Mrs. Eugene Diamond is the president of the local organization. Birthright is incorporated not for profit in the State of Illinois and all income comes from voluntary contributions. No salaries are paid to any of the staff.

The central idea which underlies the Birthright organization is that every pregnant woman, regardless of her individual circumstances, should receive whatever assistance is necessary to allow her to bear her child despite economic hardship, mental distress, or social discrimination.

Experience at other Birthright centers indicates that many of its callers are in need of medical care. Psychiatric help, obstetrical care, pregnancy testing, help with problems related to drug abuse, and hospitalization will be provided by the medical advisory board.

The basic purpose of Birthright is to reach and help the expectant mother and to provide alternatives to the pressures that drive many alienated and confused women to seek illegal abortions.

The age-old problem of the crisis pregnancy has grown to frightening proportions in the age of the "sexual revolution." More and more women find themselves unable to cope with pregnancy-related problems and look for solutions to complex situations in available community resources. Birthright of Chicago, a unique counseling service for pregnant women, will offer services for unwanted pregnancies. The organization opened its offices in January, and provides a "hot-line" telephone service, without cost, to any pregnant woman in need of help.

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## ***Political satirist, featured speaker At ISMS Public Affairs Dinner***

Mark Russell, well-known Washington political satirist, will be the featured speaker at the annual ISMS Public Affairs Dinner, at 6 p.m., Monday, May 17, at the Arlington Park Towers Hotel.

*The Washington Star* had this to say about him: "Russell, like any good comedian, defies rigid categorization, but the final product is Russell's own—wry, zany, and sometimes biting."

*The New York Times* remarked: "Mark Russell is the Capital's own funny man. His comment on the local scene is as much a part of Washington as the Congressional Record."

The 7 p.m. dinner will be preceded by cocktails at 6 p.m. in the Jimmy Durante Room.

U.S. Senator Adlai Stevenson III and Lt. Gov. Paul Simon have also been invited to speak at the dinner.



# what goes on

**a guide to continuing education**

## **March 17-18—The Cleveland Clinic Educational Foundation**

### *"Blood Banking"*

#### *Postgraduate Course*

A Review of the Nation's Blood Resources, Walter J. Zeiter, M.D.  
Organization of a Community Blood Program, Louise J. Keating, M.D.  
The Role of the Commercial Bank in Meeting the Community's Blood Needs, Hugh F. McCorkle, M.D.  
Donor Recruitment in a General Hospital, John S. Mackrell, Jr., M.D.  
The Role of the Computer in Blood Bank Operations, Thomas L. Gavan, M.D.  
Screening Donors for G6PD Deficiency, Colin R. MacPherson, M.D.  
The Availability and Utilization of Group O Blood, John W. King, M.D.  
Transfusion Malaria, Marjorie M. Smith, M.D.  
Australian Antigen Studies, Loren J. Wolsh, M.D.  
The Diagnosis and Treatment of Post Transfusion Hepatitis, Eugene I. Winkelman, M.D.  
Recent Experiences in the Examination of Amniotic Fluid, Colin R. MacPherson, M.D.  
Chemical Changes in Stored Blood, Charles E. Willis, M.D.  
Treatment of Transfusion Reactions by Renal Dialysis, Donald G. Vidt, M.D.  
Histocompatibility Tests in Organ Transplants, William E. Braun, M.D.  
Platelet Transfusions, George C. Hoffman, M.D.  
Old Blood or Fresh Blood in the Operating Room, George A. Kellner, M.D.  
Transfusion of the Ambulatory Patient, John B. Battle, Jr., M.D.  
Exchange Transfusion in the Adult, John S. Hewlett, M.D.

Automated Blood Typing, Ruth Gorman, M.T.  
The Status of Blood Component Therapy, Sanford P. Benjamin, M.D.  
Paternity Exclusion Studies—Report of Recent Experiences, Roger W. Marsters, Ph.D.  
Quality Control in the Blood Bank, John W. King, M.D.

2020 E. 93rd St., Cleveland, Ohio

## **March 24-25—The Cleveland Clinic Educational Foundation**

### *"Medical Progress and Its Relationship to Dentistry"*

#### *Postgraduate Course*

Blistering Diseases of the Skin, James G. Ryan, M.D.  
Toxic Effects of Common Drugs, Thomas E. Gretter, M.D.  
Recent Advances in the Use of Insulin for Diabetes Mellitus, Penn G. Skillern, M.D.  
A Surgeon Looks at the Problem of Hernias, Robert E. Hermann, M.D.  
Orofacial Structures and the Articulation of Speech, Eugene M. Batza, Ph.D.  
What is an Adequate Physical?, Alfred M. Taylor, M.D.  
Panel Discussion: "Coronary Artery Disease?"  
Rene G. Favalaro, M.D.  
James R. Hodgman, M.D.  
William C. Sheldon, M.D.  
The Problem of Predictive Medicine, Emanuel Cherskasing, M.D., D.M.  
Is It Worthwhile to Treat Hypertension?, Ray W. Gifford, Jr., M.D.  
Diet Control, Beatrice L. Bonarrigo  
The Swollen Leg—Diagnosis and Treatment, Jess R. Young, M.D.  
Current Concepts in Ophthalmology, Froncie A. Guttman, M.D.  
Lesions of the Mouth, Shattuck W. Hartwell, Jr., M.D.  
Classification and Treatment of Chronic Headaches, Robert S. Kunkel, M.D.  
Anxiety, A. Dixon Weatherhead, M.D.  
Drug Abuse, Richard A. Schwartz, M.D.  
Emotional and Systemic Factors Influencing Salivation in the Human, Ira L. Shannon, D.D.S.  
How Do You Define the Hyperactive Child?, Robert D. Mercer, M.D.  
Sterilization of Instruments, Eleanor Reilly, R.N.

2020 E. 93rd St., Cleveland, Ohio

## **March 31-April 2—The Children's Memorial Hospital**

### *Pediatric Neuroradiology*

#### *Symposium*

Basic innovation by coordinating the fields of pediatrics, neurology, neurosurgery, and neuroradiology. The pediatrician will render the clinical picture as an exercise in problem solving, followed by a clinical-anatomical description of the disease by the pediatric neurologist. The neuroradiologist will discuss his approach toward a definitive diagnosis, detailing the neuroradiologic characteristics of the disease and providing neuroradiologic criteria to help determine operability and assist in planning surgical technique. The pediatric neurosurgeon will present the criteria, technique, and expected results of surgery.

General discussion will include the role of radiation therapy in the treatment of parasellar tumors, trends

*(Save for reference)*



in hydrocephalus research, and the demands which microsurgery is making of the neuroradiologist.

2300 Children's Plaza, Northwestern University Medical School, Chicago

### **March 31-April 1—The Cleveland Clinic Educational Foundation**

#### *"Updating Neurology"*

##### *Postgraduate Course*

Hypertension and Its Relation to Cerebrovascular Disease, Ray W. Gifford, Jr., M.D.

Retinal Angiography, Froncie A. Gutman, M.D.

Diagnostic Methods in Cerebrovascular Disease, Richard Janeway, M.D.

Inflammatory Angiopathy of the Nervous System, Thomas W. Wallace, M.D.

Non-Arteriosclerotic Causes of Stroke, Milton B. Good, M.D.

Panel Discussion: Diagnosis of Cerebral Vascular Disease

John Gilroy, M.D.

Milton B. Good, M.D.

Thomas E. Grotter, M.D.

Richard Janeway, M.D.

Thomas W. Wallace, M.D.

Treatment of Cerebral Vascular Disease, Thomas E. Grotter, M.D.

The Electroencephalogram in Death, Charles E. Henry, Ph.D.

Extracranial Vascular Surgery: Indications & Results, Edwin G. Bevan, M.D.

Medical Treatment of Cerebral Vascular Disease, John Gilroy, M.D.

Panel Discussion: Treatment of Cerebral Vascular Disease

Edwin G. Bevan, M.D.

John Gilroy, M.D.

Charles E. Henry, Ph.D.

Richard Janeway, M.D.

Guy H. Williams, Jr., M.D.

Neurological Complications of Lipoprotein Disorders, Guy H. Williams, Jr., M.D.

Treatment of Parkinson's with L-DOPA: Indications & Results, Milton B. Good, M.D.

Slow Virus Infections of the Nervous System, Kenneth Johnson, M.D.

Tarsal Tunnel Syndrome, Thomas E. Grotter, M.D.

Vascular Headaches, Hershel Goren, M.D.

Electronystagmography, Willard Parker, M.D.

2020 E. 93rd St., Cleveland, Ohio

### **April 1-3—University of Wisconsin**

#### *Pediatric Immunology*

##### *Conference on Inappropriate Immunity*

Present the current views of pathophysiology, diagnosis and treatment of states of inappropriate immunity. Provide interchange of information between practitioner and nationally known educators via small group discussions. Translate the activities of the research worker into action at the bedside and in the clinic.

Mechanisms of Allergic Response

Allergy—2001 A.D.

Pharmacologic Suppression of Allergic Disorders

The Use and Abuse of Gamma Globulin

Wisconsin Center, Madison, Wisconsin

### **April 2-3—American Medical Association**

#### *5th National Congress on the Socio-Economics of Health Care*

Explore existing projects and programs designed to improve physician productivity and promote efficiency in the health care system by examining Foundations for Medical Care—Their Concepts and Operations, and investigating electronic data processing applications to the economics of health care. Identify the status of federal legislation and its potential impact on the organization, financing and delivery of health services.

Caesars Palace, Las Vegas, Nevada

### **April 5-6—The Cleveland Clinic Educational Foundation**

#### *"Second Annual Sports Medicine Symposium"*

##### *Postgraduate Course*

Initial Care of the Injured Athlete, Victor Ippolito, M.D.

Neck Injuries—Recognition in Early Years of Competition, Tony Adamle, M.D., Tom Phillips

Mechanics of Head and Neck Injuries, Joseph D. Godfrey, M.D.

The Cross Body Block as a Cause of Knee Injuries, Thomas Peterson, M.D.

Treatment of the Acutely Injured Knee, Joseph D. Godfrey, M.D.

Medical Interference in the Athlete, Robert D. Mercer, M.D.

Evaluation, Significance and Treatment of Elevated Blood Pressure, Donald G. Vidt, M.D.

Exercise and the Heart, Herman K. Hellerstein, M.D.

Taping Demonstration, Leo Murphy, Jack McNeely,

Tim Canty

Mechanism of Ski Injuries, Arthur E. Ellison, M.D.

Shoulder Injuries, Carl L. Nelson, M.D.

Little League Elbow, Charles M. Evarts, M.D.

Injuries of the Lower Extremity in Skiing, Arthur E. Ellison, M.D.

The Eye in Sports, Froncie A. Gutman, M.D.

Genitourinary Problems in the Athlete, Ralph A. Straffon, M.D.

Abdominal Injuries in Athletics, Caldwell B. Esselstyn, M.D.

Tennis—A Lifetime Sport, Robert Malaga, L.L.B.

Medicolegal Aspects of Sports, Crawford Morris, L.L.B.

Principles of Training, Lawrence Golding, Ph.D.

Panel on Condition, Prevention, Treatment and Rehabilitation of the Athletic Injury

Lawrence Golding, Ph.D.

Leo Murphy

Jack McNeely

Tim Canty

2020 E. 93rd St., Cleveland, Ohio

### **April 9-10—University of Kentucky**

#### *"Obstetrical Analgesia—Anesthesia and Neonatology"*

##### *Postgraduate Course*

The purpose of this course is to review the means of providing safe and satisfactory analgesia for the woman in labor with either normal or complicated conditions of delivery.

College of Medicine, University of Kentucky, Lexington, Kentucky

(Save for reference)

**April 13-15—McGraw-Hill Publications Company**

*Third National Conference and Exposition on Electronics in Medicine*

A meaningful conference on the application of electronics technology to medical care.

Sheraton Boston Hotel, Boston, Massachusetts

**April 19-22—American Industrial Health Conference**

*Annual meetings*

Industrial Medical Association and  
American Association of Industrial Nurses

The Marriott Hotel, Atlanta Georgia

**April 20—American College of Surgeons**

*Musculo-Skeletal Trauma Meeting*

Loyola Hospital, 2160 South First Avenue,  
Maywood

**April 19-21—American Academy of Pediatrics**

*Annual Spring Session*

Deviant voice as a symptom of physical and emotional disorder in children, the pediatrician's role in

*(Save for reference)*

ecology, intensive care units for high risk infants—concepts and relationship to the community, and pediatric evaluation and management of learning and behavioral disorders (including drug therapy) are among the subjects scheduled to be presented during the session.

Chase-Park Plaza Hotel, St. Louis, Missouri

**April 19-21—American Diabetes Association**

*Postgraduate Course in Diabetes*

In addition to workshops and panel discussions, morning and afternoon sessions of the three day course will include presentations of the following subjects: Diabetes 1971, Incidence and National Consequences of Diabetes, Diagnosis of Diabetes, Detection and Screening of Diabetes, Treatment of the Insulin-Dependent Diabetic, Treatment of the Non-Insulin Dependent Diabetic, the Present and Future Role of the Pharmacist in Diabetic Care. Other subjects to be covered are: Preventable Complication: Foot Lesions, Ketacidotic Coma, Nonketotic Coma, Hypoglycemia (Insulin Reaction), Genetic Counseling, Birth Control, The Teenage Diabetic: Social and Psychological Problems, Chronic Complications of the Diabetic Patient, The Blind Diabetic, Special Problems of the Economically Deprived Diabetic, Role of the Diabetes Association in Patient Care, Diabetic Camp, Present and Future Management of the Diabetic.

University of California, San Francisco, California

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## ***ISMS Convention to bring Illinois physicians close together***

The 131st annual meeting of the Illinois State Medical Society will open May 16, with a completely new format designed to bring the physicians of Illinois closer together at a time when profound changes are facing their profession.

The beautiful new Arlington Park Towers Hotel was chosen for this meeting because it is convenient to Chicago, and meets the many needs of a suitable Convention site. Doctors and their wives can combine business with pleasure at this spacious hotel and its surroundings.

Wives, especially, are encouraged to attend this year's meeting, where they can participate in bridge and golf tournaments, attend a Bonwit Teller fashion show, visit nearby shopping centers, spend a day at the races, or simply relax around the hotel pool. Shuttle buses will provide transportation to Chicago's Loop.

The policy-making body of the society, the House of Delegates, will meet Sunday afternoon, May 16, and reference committee meetings are scheduled for that evening. All ISMS members are invited to attend meetings of the House and

participate in reference committee hearings. Recommendations of the reference committees are discussed and voted upon at subsequent meetings of the House on Tuesday and Wednesday.

Educational and scientific programs start Monday morning, May 17. The following is a preliminary schedule of events:

### **Monday**

Illinois Surgical Society operative clinics at 8 a.m. and grand rounds at 11 a.m. at Cook County Hospital. Moderators for the clinics will be Peter Rosi, M.D., colon surgery; Walter Barker, M.D., thoracic surgery; John Bergan, M.D., vascular surgery; John Boswick, M.D., hand surgery, and Robert Freeark, M.D., biliary surgery.

Dr. Frank C. Spencer, chief of surgery at New York University and Bellevue Hospital, New York, will conduct grand rounds at 11 a.m. at Cook County Hospital and will speak on "Coronary Revascularization" during the Surgical Society's afternoon program at the hotel. Two



## ISMS Convention, May 16-19 . . .

panel discussions are also on the afternoon program. Edward Paloyan, M.D., professor of surgery at the University of Chicago, will moderate a program on "Hypercalcemia and the Surgeon" and Dr. Robert Baker, professor of surgery at the University of Illinois, will head a panel on "Multiple Trauma."

Other features on Monday are a joint ISMS-Bar Association meeting on malpractice, and a program conducted by the Illinois Obstetrical and Gynecological Society. Details are not yet available on the latter.

"Today's Youth" will be the topic of a general session on Monday afternoon when new insights may be gained into how teenage patients (or own children) feel about the drug scene, campus protest and changing sexual patterns. Dr. David E. Smith, founder and director of the Haight-Ashbury Medical Clinic in San Francisco, will be the featured speaker. Dr. Smith, assistant clinical professor of pharmacology at the University of California and editor of the *Journal of Psychedelic Drugs*, is the author and co-author of books on youth's alienation and the drug scene.

Monday's activities end with the annual Public Affairs Dinner, where Mark Russell, political satirist, will be the featured speaker.

### Tuesday

The University of Illinois Medical Alumni Association is planning an all-day meeting at the campus and at the hotel, culminating in dinner which this year will be combined with the annual ISMS President's Banquet. Other events of the day include a general session presented

by the American Cancer Society; a program on treatment considerations in anxiety and tension, depression and suicide, and emotional problems of the aged; and an allergy program covering aspergillosis in a family, cardiac arrhythmias due to foods, parotid gland allergy, perforated nasal septum due to nasal sprays, paradoxical effects of Isuprel aerosol therapy in status asthmaticus, ophthalmic allergy due to horradendrum, and rehabilitation of the asthmatic child.

About 35 physicians are expected to become members of the ISMS Fifty-Year Club at the Club's annual luncheon on Tuesday. Dr. George Shropshire, first vice president of ISMS, will preside.

### Wednesday

Highlights of Wednesday's program will be a general session on human sexuality, a panel on emergency room problems and procedures by George Anast, M.D., David Boyd, M.D., Harold Paul, M.D., and John Schneewind, M.D., and a pediatric program.

Additional program details are awaiting confirmation.

On each of the three days of Convention, physicians may participate in one of 12 instructional courses (registration materials have been individually mailed to members) and various exhibits, which will be open from 9 a.m. to 5 p.m. daily. The exhibits include medical self-testing, scientific exhibits, an exhibition of physician art and technical exhibits.

There is no admission charge for any convention activity, except for the instructional courses, banquets and luncheons planned by specific groups.

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## *A vaccine for mononucleosis*

Scientists at Northwestern University may be on their way toward developing a vaccine for mononucleosis, reports the National Society for Medical Research.

Antigens from red blood cells of beef and sheep are under experimentation at the University, which, if found ineffective as a vaccine, may at least be used as a skin test for the disease, said the group.

*Announcing*

# An Exhibition of Physician Art

**(also open to physicians' wives)**

To be shown and judged during the 131st annual meeting of the Illinois State Medical Society

**May 17-19, 1971  
Arlington Park Towers  
Arlington Heights, Illinois**

**Deadline for entries:** Notification of intent to exhibit must be received by April 1, 1971. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

**Requirements:** (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. Due to limited exhibit space, these categories must be strictly adhered to. Decisions regarding category eligibility will be left to the discretion of the judges. (3) All entries must be delivered to the Jimmy Durante Room, Arlington Park Towers, between 8 a.m. and 12:00 noon, on Saturday, May 15, and must be picked up from the display area by noon Thursday, May 20. It is hoped that no paintings will be removed from the exhibit before this time.

**Judging and Awards:** Ribbons will be awarded by a panel of professional artists.

**Limited Liability:** The Illinois State Medical Society will provide guards for the exhibit from noon, Saturday, May 15, to noon, Thursday, May 20, but cannot assume responsibility for damage or theft of art submitted.

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## Notification of Intent to Exhibit

Mail to Convention Manager, ISMS, 360 North Michigan Avenue, Chicago, Illinois 60601.

I plan to submit the following entries to the 1971 ISMS Art Exhibit. Three entries allowed per individual. Please circle classification of each.

1. .... oil, watercolor, sculpture, other  
(title)

2. .... oil, watercolor, sculpture, other  
(title)

3. .... oil, watercolor, sculpture, other  
(title)

Name .....

Address .....

City & State ..... Zip .....

Phone .....





# new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Products**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

\* \* \* \* \*

The following new drugs have been marketed:

## DUPLICATE SINGLE PRODUCTS

**CORTICOTROPIN** Hormones-ACTH R

**Manufacturer:** Wyeth

**Nonproprietary name:** Corticotropin (USP)

**Indications:** Anterior pituitary hormone therapy

**Contraindications:** The usual contraindications for corticotropin therapy must be observed.

**Dosage:** Individualized

**Supplied:** Pre-filled steril cartridge needle units (TUBEX): Each cc contains 40 or 80 USP units of repository corticotropin

**EDEMEX** Diuretics-Benzothiazides R

**Manufacturer:** Savage

**Nonproprietary name:** Benzthiazide

**Indications:** Diuresis, in the presence of edema due to various causes

**Contraindications:** Anuria, hypersensitivity to all sulfonamide derivatives, progressive renal and hepatic diseases

**Dosage:** Average dose: 50-200 mg. daily.

**Supplied:** Tablets, 50 mg.

**FURACHEL** Antiinfectives-Urinary R

**Manufacturer:** Rochelle

**Nonproprietary name:** Nitrofurantoin

**Indications:** Pyelonephritis, pyelitis and cystitis

**Contraindications:** Anuria, oliguria or significant impairment of renal function; Pregnancy at term and infancy under 3 mos.

**Dosage:** Adults: 50-100 mg. q.i.d.

Children: 5-7 mg./kg./24 hrs. in divided doses q.i.d.

**Supplied:** Tablets, 50-100 mg.

**OXYTOCIN** Oxytocic R

**Manufacturer:** Wyeth

**Nonproprietary name:** Oxytocin (USP)

**Indications:** Induction of labor, control or prevention of postpartum hemorrhage and facilitation of uterine contraction

**Contraindications:** Hypersensitivity to oxytocin, conditions predisposing to uterine rupture, over 35 years of age, twin pregnancy before second twin is delivered, hypertonic patterns of labor, past history of uterine sepsis or difficult and traumatic delivery, or any condition involving fetal distress. Prolonged use in uterine inertia. Do not give simultaneously by more than one route.

**Dosage:** i.v. and i.m., individualized

**Supplied:** Pre-filled steril cartridge needle units (TUBEX) Each cc contains 10 U.S.P. units

**PFIZERPEN-AS** Penicillin and Derivatives R

**Manufacturer:** Pfizer

**Nonproprietary name:** Penicillin G procaine

**Indications:** Moderately severe infections due to penicillin G sensitive microorganisms.

**Contraindications:** Hypersensitivity to penicillin or procaine

**Dosage:** Individualized

**Supplied:** Vials, aqueous suspension: Each cc contains 300,000 units procaine penicillin G ISOJECT disposable syringes: Each cc contains 600,000 units

**UTICILLIN VK** Penicillin & Deriv. R

**Manufacturer:** Upjohn

**Nonproprietary name:** Penicillin Phenoxymethyl Potassium (USP)

**Indications:** Treatment of bacterial infections that respond to oral penicillin G therapy.

**Contraindications:** Hypersensitivity to penicillin

**Dosage:** Individualized

**Supplied:** Tablets, 250 and 500 mg.

### COMBINATION PRODUCTS

**DUCON** Antacid o-t-c

**Manufacturer:** Smith Kline & French

**Composition:** Each 5 cc contains:

Aluminum hydroxide 720 mg.

Magnesium hydroxide 350 mg.

Calcium carbonate 375 mg.

**Indications:** Relief of symptoms associated with gastric hyperacidity.

**Contraindications:** Renal insufficiency or phosphate depletion. Not recommended for children under 12 years.

**Dosage:** Two to three tsp. after meals and at bedtime or as needed (40-60cc daily)

**Supplied:** Suspension

**GENTLAX S** Laxative o-t-c

**Manufacturer:** Purdue Frederick

**Composition:** Standardized senna concentrate  
Dioctyl sodium sulfosuccinate

**Indications:** Functional constipation

**Contraindications:** Acute surgical abdomen

**Dosage:** Adults: 2 tablets (maximum dosage—4 tablets b.i.d.)

Children: (above 60 lbs.): 1 tablet  
(maximum dosage—2 tablets b.i.d.).

**Supplied:** Tablets

**LASAN** Dermatological Prep. R

**Manufacturer:** Stiefel

**Composition:** Anthralin (NF) 0.2% or 0.4%  
Lassar's Paste

Zinc oxide

Cornstarch

White petrolatum

**Indications:** Psoriasis

**Contraindications:** Renal disease, areas of the skin where inflammation is present. Do not use on or near eyes or in acute eruptions.

**Dosage:** Apply to plaque sites at bedtime. Remove the following morning with warm oil followed by a bath.

**Supplied:** Ointment

**LASAN POMADE** Dermatological Prep. R

**Manufacturer:** Steifel

**Composition:** Anthralin (NF) 0.4%

Cetyl alcohol

Mineral oil

Sodium lauryl sulfate

Petrolatum

Salicylic acid

**Indications:** Psoriasis of the scalp

**Contraindications:** Renal disease, areas of the skin where inflammation is present. Do not use on or near eyes or in acute eruptions.

**Dosage:** Massage into scalp at bedtime. Remove the following morning with shampoo.

**Supplied:** Pomade

**SULFALOID** Antiinfectives-Sulfonamides R

**Manufacturer:** Westerfield

**Composition:** Each 5 cc contains:

Sulfadiazine 167 mg.

Sulfamerazine 167 mg.

Sulfamethazine 167 mg.

**Indications:** Infections due to susceptible organisms. As adjunctive therapy in toxoplasmosis, malaria and hemophilus influenzae meningitis.

**Contraindications:** Hypersensitivity to sulfonamides. Infants under 2 months of age (except in treatment of congenital toxoplasmosis), pregnancy at term and during nursing period.

**Dosage:** Adults: Initially, 2 to 4 grams, followed by 2-4 grams/24 hrs. divided into 3-6 doses/24 hrs. Children: Initially one-half the 24 hr. dose, followed by 150 mg./kg./24 hrs. in 4-6 divided doses/24 hrs. with a maximum of 6 grams/24 hrs.

**Supplied:** Oral suspension: 2,3 and 4 fluidounce, pints and gallons.

**UTICILLIN VK** Penicillin & Deriv. R

**Manufacturer:** Upjohn

**Nonproprietary name:** Penicillin Phenoxymethyl Potassium (USP)

**Indications:** Treatment of bacterial infections that respond to oral penicillin G therapy

**Contraindications:** Hypersensitivity to penicillin

**Dosage:** Individualized

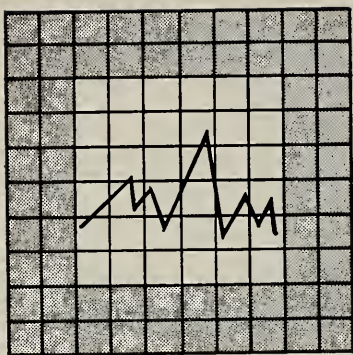
**Supplied:** Granules for oral solution.

Each 5 cc contains 125 or 250 mg.

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"It is better to be silent and be thought a fool than to speak up and remove all doubt."—Abraham Lincoln.



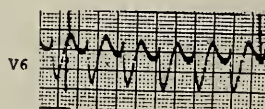
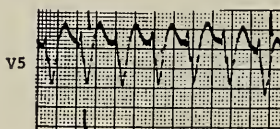
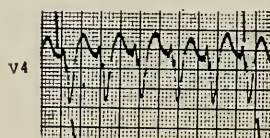
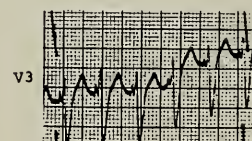
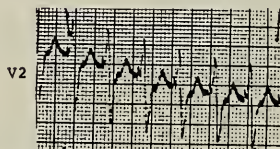
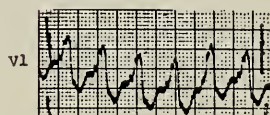
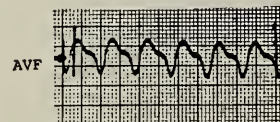
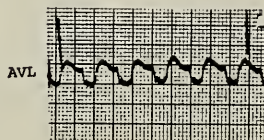
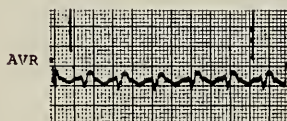
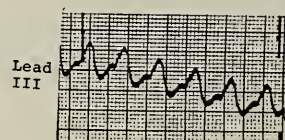
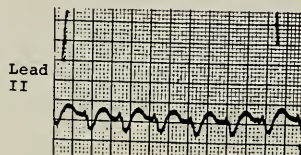
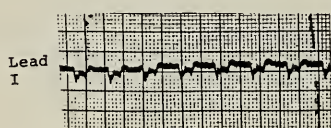


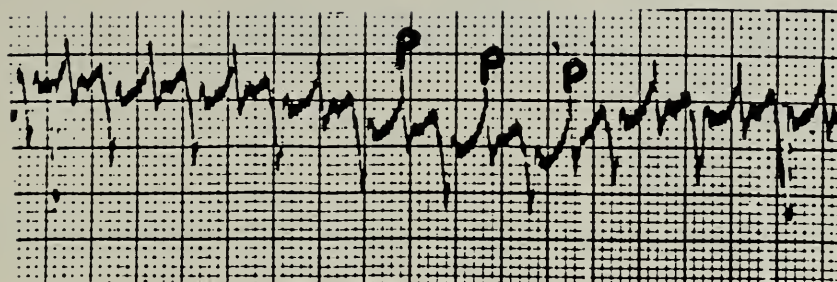
# ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS,  
M.D. AND PATRICK SCANLON, M.D./SECTION OF CARDIOLOGY,  
DEPARTMENT OF MEDICINE  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

A 52-year-old male was admitted to the hospital emergency room complaining of sudden onset of palpitation and compressing substernal chest pain one hour previously. Physical examination revealed a pale, anxious patient with a regular pulse rate of 166. B/P 110/85. Neck veins slightly distended while reclining at 45°.

No palpable lifts or thrills were present. Auscultation disclosed  $S_1$  to be of constant intensity at PMI and  $S_2$  to be widely split at 3rd Lt. Past history disclosed a history of similar episodes of palpitation but prior episodes had not been accompanied by chest pain. The patient had not been taking drugs. The ECG (Fig. 1) showed





ventricular rate of 166 and QRS of 0.12 seconds. Right carotid sinus pressure did not alter the rate or rhythm.

**Questions:** (One or more of the following statements may be correct.)

1. Atrial tachycardia with aberrant ventricular conduction (RBBB) is present.

2. Ventricular tachycardia is present.

3. Angina pectoris is present.

4. The patient should be digitalized.

5. An esophageal lead might yield critical information.

(See page 298)

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## ***Arlington Park Towers— New ISMS Convention site***

The ISMS Annual Meeting on May 17-19, will have a brand new home this year—the multi-million dollar, Arlington Park Towers Hotel.

Conveniently located just 30 miles northwest of Chicago's Loop, the hotel offers the latest in living and entertainment accommodations.

The famous Arlington Park Race Track is adjacent to the hotel grounds and thoroughbred racing will be held Monday through Wednesday during the annual meeting.

An 18-hole golf course with nine holes lighted for evening play, a double-deck golf driving range, and heated, glass-enclosed swimming pool are just a few of the extras offered by the hotel.

Free bus service will be available between the hotel and Chicago's Loop and West Side medical center. The hotel offers complimentary limousine service to and from O'Hare Airport, and the Chicago and Northwestern Railroad has special rate trains as well as a regular commuter train leaving the station located on the hotel grounds.

In addition, the hotel has free parking space for more than 3,000 cars. Make your reservations now through Perry Smithers, Convention chairman, ISMS, 360 N. Michigan Ave., Chicago 60601, or phone, 782-1684.





## editorials

### An ego-deflater

Medical terminology is highly complicated now that the scientific disciplines are becoming more complex. We were intrigued with the following title in a recent issue of the *British Medical Journal*, "Membranoproliferative Glomerulonephritis and Persistent Hypocomplementaemia."

Thirty years ago, relatively simple clinical and necropsy studies determined the classification of glomerulonephritis. Renal biopsy, however, changed this. A complete diagnosis of renal disease now includes detailed descriptions of the clinical picture, of the renal lesions, and of the cause. According to the *British Medical Journal*, glomerulonephritis is an assortment of pathological conditions and has five subdivisions: minimal change, focal glomerulosclerosis, membranous (epimembranous) nephropathy, proliferative glomerulonephritis, and chronic glomerulonephritis. But this is not all. Proliferative glomeru-

lonephritis, for example, also has five subdivisions and the membranoproliferative form is the type mentioned in the article.

We recommend the full article<sup>1</sup> and editorial<sup>2</sup> comments on it to our readers. It will deflate the ego of even those physicians who have been in active practice for two or three decades, unless, of course, their specialty is renal disease. Your editor was disappointed to read that "The cause of the hypocomplementaemia in membranoproliferative glomerulonephritis is at present uncertain, as is the etiology of the nephritis."

T. R. Van Dellen, M.D.

#### References

1. Cameron, J. S., et al., "Membranoproliferative Glomerulonephritis and Persistent Hypocomplementaemia," *Brit. Med. J.*, (Oct. 3) 1970, pages 7-14.
2. Ibidem. RENAL GLOMERULAR DISEASE, pages 3 and 4.

### A house divided?

A great patriarch of the United States, Abraham Lincoln, observed that "a house divided cannot stand." In a similar vein, other great thinkers have expressed concepts which support this: "United We Stand, Divided We Fall;" "*E Pluribus Unum*" (one composed of many). Think about these for a moment.

In these days of turmoil and strife, when a so-called "revolution" is "happening" in our country, it is imperative that we all pull together, re-dedicating ourselves and placing personal ambitions second to the common good.

Dr. Walter C. Bornemeier, president of the AMA, in his inaugural address indicated his concern about this. He called for action beneficial to all the people, by a united, unified profession. He deplored the factionalization of the medical community and the apparent divisiveness caused by some groups and societies. ISMS president Dr. J. Ernest Breed has concurred in and echoed some of these thoughts. We applaud the efforts and statements of these leaders in medicine. The call is to unity, to achieve a recognized common goal; maintenance of health for the populace.

To achieve this, everyone must be willing to give a little, and this pertains to the proliferating specialty groups with a propensity for promoting only their own group and its activities. Each must exert special effort to cooperate with others, especially the state medical societies, which have been established to represent all physicians with no regard to specialty or other affiliation.

Doctors of medicine have come under a great

deal of editorial abuse, undeservedly, due to many factors. To combat this it is imperative that all of medicine unite.

Another adage to be recalled, and a prime strategy in military and political planning and logistics is "Divide and Conquer." Let medicine not divide itself or it shall be at the mercy of the adversaries who call for change in many things which we know to be good.

R. A. Ott

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## *Clinics for Crippled Children scheduled*

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will hold 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic, any child or children for whom he may want examination or consultative services.

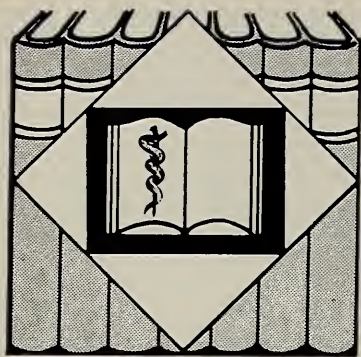
- April 1 Sterling—Community General Hospital
- April 1 Springfield—St. John's Hospital
- April 1 Flora—Clay County Hospital
- April 1 Cairo—Public Health Department
- April 1 Lake County Cardiac—Victory Memorial Hospital
- April 2 Chicago Heights Cardiac — St. James Hospital
- April 6 Quincy—St. Mary's Hospital
- April 7 Rock Island Cerebral Palsy — 3808 Eighth Avenue
- April 7 Hinsdale—Hinsdale Sanitarium.
- April 13 East St. Louis—Christian Welfare Hospital
- April 13 Peoria—St. Francis Children's Hospital
- April 14 Champaign-Urbana—McKinley Hospital
- April 14 Mt. Vernon—Good Samaritan Hospital
- April 15 Bloomington—Mennonite Hospital
- April 15 Rockford—Rockford Memorial Hospital

- April 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- April 21 Chicago Heights General—St. James Hospital
- April 23 Chicago Heights Cardiac—St. James Hospital
- April 23 Evanston—St. Francis Hospital
- April 26 Peoria Cardiac—St. Francis Children's Hospital
- April 27 Belleville—St. Elizabeth's Hospital
- April 27 Peoria—St. Francis Children's Hospital
- April 27 Rock Island Area General — Moline Public Hospital
- April 28 Springfield Pediatric Neurological — Diocesan Center
- April 28 Centralia—St. Mary's Hospital
- April 28 Aurora—Copley Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.





# the doctors library

## **Textbook of Nuclear Medicine Technology.**

By Paul J. Early, Mohammed Abdel Razzak and D. Bruce Sodee. The C. V. Mosby Company, St. Louis, 1969.

Nuclear medicine is one of the most rapidly growing medical specialties today. Training programs for physicians as well as technologists have been unable to keep up with the demand for trained personnel. The establishment of Nuclear Medical Technology training programs has, in many instances, awaited the approval of a standard curriculum. Once a curriculum is established, then texts must be used effectively by the students to enable them to digest the needed information.

The authors of this book have had experience with a very good technologist's training program and their thoughtfulness shows throughout in the completeness of the text. The material presented is very well illustrated and quite readable. One area which could be expanded in future editions of this book is that of dispensing of doses and concomitantly record keeping. This is handled in a very short section under "Radiation Health Safety."

Directors of Nuclear Medicine Technology training programs would be well advised to incorporate this volume as a standard text in their program. The authors are to be commended for the content as well as the timeliness of this work.

James L. Quinn III, M.D.

**Fetal Autonomy.** Edited by G. E. W. Wolstenholm and M. O'Connor. Churchill Ltd., London, 1969. VIII: 326 pages.

This book records a Ciba Foundation Symposium in which sixteen scientists presented the results of their researches—all dealing with the general thesis that the human fetus exhibits a high degree of autonomy in regulating its own

functions. These topics range from the role of the fetus as an allograft, to the role of fetal hormones in programming the central nervous system. Each presentation is followed by a discussion which is illuminating both as to details known, and significant areas still scarcely touched. In his closing remarks, the chairman spoke somewhat facetiously as follows:

*"The foetus has been likened to a space-man: passive, insulated, and preserved from stimuli—which is only half true. On the contrary, one could think of the mammalian embryo as a hitchhiker with a large pack on his back, getting into a rather small car; he is a friendly fellow who chatters away all the time and is prepared to do some driving if given half a chance—he takes you off your route and tells you when and where he would like to get out."*

L. B. Arey

**Physiology of the Gastrointestinal Tract.** By E. Clinton Texter, Jr., M.D., Ching-Chung Chou, M.D., Higinio C. Laureta, M.D. and Gaston R. Vantrappen, M.D. The C. V. Mosby Company, Saint Louis, 1968. 262 pp.

This multi-authored textbook attempts to delineate the areas of gastrointestinal physiologic knowledge most relevant to medical practice. It contains unusual as well as usual data.

Chapter 1 deals with splanchnic circulation, and this section comprises 20% of the book by volume. Considerable experimental data, theory and methodology pertaining to splanchnic circulation is included. The reader finally learns that these authors as well as other authorities cannot accurately relate splanchnic circulation to digestive function although these functions "appear to be related to and depend on blood flow to a degree." The fundamental importance of circulation to digestive function is unques-

tioned, but one must question these data with reference to the stated objectives of the authors. Author interest notwithstanding, the details of this section would ordinarily be sought in a treatise devoted to circulation per se rather than a text claiming relevance to medical practice.

Chapter 8 introduces the second major section of the book concerning gastrointestinal motility and comprises 30% of the book by volume. Two of the authors have expended considerable energy in this area, but utilize surprisingly few of their own illustrations in these chapters. This is unquestionably the heavy portion of the text. Smooth muscle physiology is discussed completely; neural and hormonal control receives authoritative attention. In total, the eight chapters devoted to motility are pertinent, complete and well written. Illustrations throughout the book, as well as in this particular section, are numerous and well chosen.

The remaining half of the book is devoted to secretion, digestion and absorption. These sections are written concisely in traditional fashion and the material is both recent and relevant. Gastric secretion is very well done; it is clear, references to recent data are pertinent and illustrations are well selected. These sections are lacking in depth devoted to splanchnic circulation and motility, but the material is presented logically and in a manner anticipated in a short text.

Editorial expertise is quite evident throughout, and selection of material is generally adequate. Syntax is excellent. References, while few, are recent and pertinent. Eighty per cent of the text does fulfill the aim of delineating gastrointestinal physiologic data relevant to the clinician, while 20% of the text should have considerable appeal to those interested in splanchnic circulation.

Ivan C. Kever, M.D.

## ISMS Medical Journalism Awards

Twenty-one Illinois newspaper, radio and television winners in the 1970 ISMS Medical Journalism Awards Program were honored at the annual presentation banquet Saturday evening, March 13, at the Ambassador West Hotel in Chicago.

The winners were selected on January 6, by judges from the Publicity Club of Chicago. ISMS physicians offered technical opinions, but did not have a part in final selection of winners.

Winning newspaper entries ranged from the *Chicago Tribune's* expose of ambulance service abuses in Chicago, to the tender and moving portrayal of the hell in which a woman alcoholic must live. The latter story appeared in the *Decatur Herald-Review*.

Metropolitan newspaper winners include: *Chicago Tribune*—William Jones, ambulance series; Ron Kotulak, news story; and Tom Hall, magazine feature. *Chicago Daily News*—Arthur J. Snider, feature. *Chicago Today*—Tom Watts, news analysis. *Chicago Sun Times*—

Jerome Watson, news series.

Downstate dailies: *Illinois State Journal*—Springfield, Jessica Weber, feature; *Metro-East Journal*—East St. Louis, series; *Kankakee Daily Journal*—Lloyd Elisabeth Fosse, news coverage; *Decatur Herald-Review*—Carol Pauli, news analysis.

Weeklies: *Collinsville Herald*—Pat Gauen, news series; *Park Ridge Advocate*—Ruth Trout, feature; *Evanston Review*—Mary Myers, news analysis.

In 1970, the medium of television presented revealing, yet sensitive, coverage of medical problems ranging from drug abuse to hospital care and to the ultimate disease—death.

Television awards were judged in metropolitan and non-metropolitan categories. Metropolitan winners were *WMAQ*, Chicago (Ch. 5), best documentary, and *WTTW*, Chicago (Ch. 11), best discussion program.

Non-metropolitan winners were *WCIA-TV*, Champaign, best documentary and *WICS-TV*, Springfield, best discussion program.

Illinois radio stations focused on current health problems, including several attacks on problems of drug abuse.

Metropolitan radio winners include *WIND Radio*, best documentary, and *WBBM Radio*, best discussion series. *WJOL Radio*, Joliet, with a discussion series, was a non-metropolitan winner.

A special multi-media excellence award will be presented *WGN-Continental Broadcasting Co.*, Chicago, for a comprehensive campaign against drug abuse. The campaign effectively utilized television and radio coverage of the problem as well as a series of public service display ads for use by newspapers.





## report

a service of the illinois medical assistants association

### *“A circus of ideas”*

BY IRMA DAVENPORT/VERMILION COUNTY

“A Circus of Ideas” is the theme of the 15th Annual Convention of Illinois Medical Assistants hosted this year at the Ramada Inn in Champaign by the Vermilion County Chapter on April 23-25.

The House of Delegates will meet at 1:30 on Friday afternoon with representatives from each chapter in Illinois present. On Friday evening, a dinner will be held with Dr. Carl Clark, from Sycamore, speaking on “National Health Plans.”

An excellent educational program is planned for Saturday, starting with a panel discussion on Programs, Fund Raising and Conducting Meetings. This should provide valuable information and ideas which can be taken back to the local chapters and put to use. Mrs. Marie Young of Indiana, president of the American Association of Medical Assistants, will be one of the panel members.

Also on the program for Saturday morning, will be a discussion of “The Emotions of the Terminally Ill Patient.” At noon the Annual

Awards Luncheon will be held, and new chapters will receive their charters. Awards will be presented for Distinguished Service, Membership and the best Chapter History Book.

Topics to be presented during the afternoon are “Abortion-Should Illinois Law be Changed?,” “Information from the Health Insurance Council” by George W. Wells, and “Suicide Prevention,” by Mrs. Betty Lazarus, the director of the Suicide Clinic at the Adler Zone Center, in Champaign.

The Installation Banquet on Saturday evening will be preceded by a social hour. A reception for the newly installed President, Jean Berschinski, of Homewood, will follow the banquet. Rev. W. B. Reed of Elgin, will speak at the banquet on “Laughter-Its Curative Power.”

Winding up the 1971 Convention, will be a breakfast on Sunday morning. Speakers at the breakfast will include Mr. Robert P. Revenaugh, a representative of Professional Business Management, in Chicago, with advice on “Efficiency in Collection Procedures,” and Mr. John Olson, of Continental Casualty Company in Chicago, telling of the Medicare regulation changes in 1971.

All Medical Assistants and/or her doctor-employer are welcome and urged to attend any or all of the above functions. For further information please contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, 60451, or Mrs. Vivian Kraft, R.R. #2, Normal, 61761.

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# *Abstracts of Board actions*

*(Continued from page 220)*

Board meetings for 1971 are March 13-14, Ambassador Hotel, Chicago; July 17-18, O'Hare Hyatt House; October 9-10, Rockford area.

## **On Alleviating the Maldistribution & Shortage of Physicians**

The Board has recommended that a \$3,312 bequest made to the Illinois Department of Health be deposited in the ISMS Educational and Scientific Foundation to be used with other available funds for a physician recruitment program in Illinois.

It also endorsed the principle amending the Medical Practice Act to allow physicians licensed in other states to practice in Illinois up to six months while satisfying requirements for Illinois licensure.

In view of proposed changes in admission policies and practices in the University of Illinois College of Medicine affecting the ISMS-IAA Student Loan program, the Fund Board was authorized to conduct an accurate statistical study of the program's 23-year effect on the downstate physician shortage.

The Board also approved a \$1,550 budget for operating the 1971 SAMA-MECO project, and directed the SAMA Advisory Committee to apply to the ISMS Foundation for a grant in this amount from unrestricted funds. The Illinois Hospital Association is expected to contribute matching funds.

## **Other Board Actions**

- Approved a recommendation of the Medical Legal Council that the Governor be urged to require state mental health facilities to meet the same minimum standards as private psychiatric facilities.
- Approved a recommendation of Trustee A. E. Livingston (5th District) that the Committee on Drugs and Therapeutics be urged to consider indicating in each category of its Drug Manual which drug is regarded by experts as the "best buy" from the standpoint of cost, efficacy, etc.
- Approved rental of additional office space which has become available across the hall from present ISMS quarters.
- Approved a membership survey focusing on socio-economic issues, deemed to be most crucial at the time the poll is taken next summer.
- Endorsed the concept that all physicians involved in a surgical case are entitled to compensation for services rendered and that the policy of some insurance carriers to pay only one physician on a case is unacceptable.
- Accepted \$3,000 from Merck, Inc., to operate the Scientific Speakers Bureau in 1971, noting that the amount was less than that which Merck has contributed for the past seven years and that county medical societies utilizing the Bureau should be notified that selective programming will be necessary.

## **Meetings—Conferences—Symposia**

Additional conferences authorized by the Board of Trustees:

1. Symposium on Nutrition and Food Technology to be co-sponsored with the Chicago Nutrition Association and the Illinois Section, Institute of Food Technologists in the fall of 1971.
2. A joint meeting with the Chicago Bar Association during the ISMS convention to discuss mutual problems.
3. A symposium to be co-sponsored with the Association of Commerce and Industry and interested medically-oriented agencies to study alternatives for meeting and solving drug abuse problems and to put into motion activities to establish necessary mechanisms.

# Rx Product Index

<i>Achrostatin</i> .....	297
Lederle Laboratories	
<i>Alpha Keri</i> .....	295
Westwood Pharmaceuticals, Inc.	
<i>Aventyl HCL</i> .....	210-212
Eli Lilly and Company	
<i>Dicarbosil</i> .....	300
Arch Laboratories	
<i>Doxidan</i> .....	232
Hoechst Pharmaceutical Co.	
<i>Empirin w/Codeine</i> .....	221
Burroughs Wellcome & Co.	
<i>Euthroid</i> .....	226-227
Warner Chilcott Laboratories Div.	
Warner Lambert, Inc.	
<i>Hygroton</i> .....	239
Geigy Pharmaceutical Corp.	
<i>Ilosone</i> .....	240
Eli Lilly and Company	
<i>Kantrex</i> .....	3rd Cover
Bristol Laboratories	
<i>Larobec</i> .....	206
<i>Librium</i> .....	276-277
<i>Noludar</i> .....	293, 301
<i>Valium</i> .....	Back Cover
Roche Laboratories Div., Hoffmann-LaRoche, Inc.	
<i>Mylanta</i> .....	225
Stuart Pharmaceutical Div., Atlas Chemical Industries, Inc.	
<i>Pro-Banthine</i> .....	2nd Cover, 205
G. D. Searle & Co.	
<i>Orenzyme/AVC</i> .....	223, 224
National Drug Company	
<i>Salutensin</i> .....	208-209
<i>Tetrex b.i.d. Caps</i> .....	234-235
Bristol Laboratories	
<i>Silain-Gel</i> .....	230-231
A. H. Robins Co., Inc.	
<i>Synthroid</i> .....	215-218
Flint Laboratories Div. Travenol Laboratories, Inc.	
<i>Seconol Sodium</i> .....	228-229
Eli Lilly and Company	

for March, 1971

295



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# Maternal Mortality

(Continued from page 244)

had sickle cell disease, and was hospitalized during the current pregnancy at thirty-six weeks gestation and given two units of packed red cells. The estimated fetal weight was four pounds. The subject was discharged home with a hematocrit of 36%. One week later, the subject was admitted to the hospital with pains in knees, shoulders and elbows. BP was 180/150, no edema nor albuminuria. Preeclamptic therapy was instituted. Convulsions occurred on the second hospital day and again on the third hospital day. Death occurred by cardiac arrest on the third hospital day. Autopsy revealed an intact intrauterine pregnancy, fetal weight 3100 grams, hepatic necrosis and splenomegaly.

*Committee judgment:* Obstetric death with preventable factors of inadequate treatment of preeclampsia and delayed termination of pregnancy.

*This article will continue in the April issue of the IMJ and cover Deaths from Hemorrhage, Infection, Anesthesia and Sickle Cell Disease.*

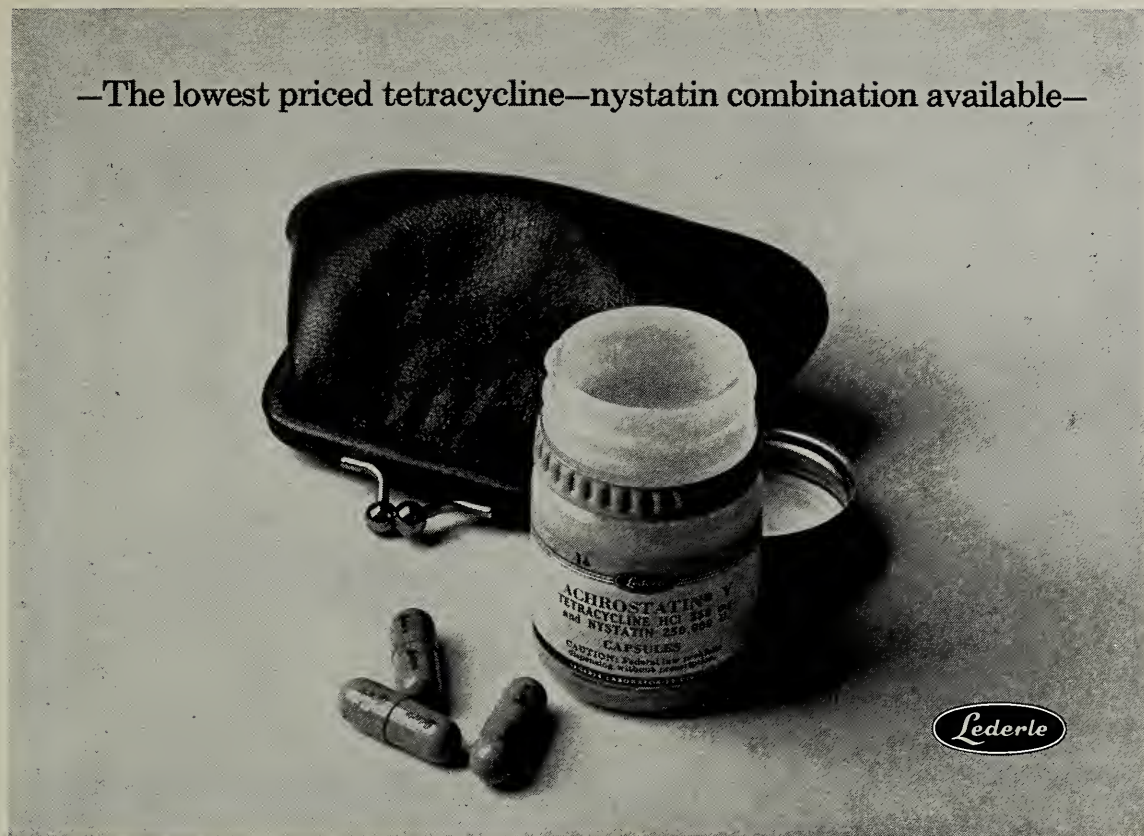
## the viewbox

(Continued from page 245)

**Diagnosis:** An avulsion of the nerve roots of C6, 7, 8 and T1—one or more nerve roots may be avulsed at any level with or without associated spinal cord injury. Myelographically, however, the root injury has been more common in the brachial plexus. The lesion is always accompanied by a serious segmental motor and sensory deficit. Myelographically, it is characterized by one or more irregular extradural extravasations of pantopaque laterally through a meningeal tear (compare the abnormal left side with the normal appearance of the right side). These outpouchings tend to have jagged, blunt margins, which differentiate them from diverticula of the subarachnoid space which characteristically have a smooth delicately rounded outline. The lesion usually occurs as a result of an acute stretching of the brachial plexus.

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## Surgical Grand Round

*(Continued from page 249)*

tremely poor without treatment. It is also interesting to note that if the site of the tear was in the descending thoracic aorta, many of these patients had a markedly elevated diastolic pressure, in contrast to the ascending aorta dissection, in which the pressure was either low or normal. If these statistics represent the natural history of the disease, perhaps one could assume that the patients that have their dissection originating in the ascending thoracic aorta should be treated surgically, and those in the descending thoracic aorta could be treated with hypotensive drugs.

To summarize this discussion, it is my opinion that patients with the clinical impression of a dissecting aneurysm should be treated for shock, if present, and an aortogram should be performed as soon as possible to confirm the diagnosis and identify the site of the intimal tear. If the intimal tear is in the ascending thoracic aorta, I believe the individual should be operated upon immediately. If the origin of the tear is in the descending thoracic aorta and the patient is hypertensive, one might consider using hypotensive drugs, but I would still prefer surgical correction. The mortality is high but I am convinced that we can salvage many more of these patients if an accurate diagnosis is made early and surgical correction is promptly instituted. ◀

## EKG of the month

*(Continued from page 287)*

### Answers:

1, 3, and 5 are correct. Figure B demonstrates the presence of a biphasic P wave prior to each QRS complex and confirm the presence of atrial tachycardia with aberrant ventricular conduction (RBBB). Since angina pectoris was present, the patient was treated by immediate DC cardio version with reversion to sinus rhythm and disappearance of both the angina pectoris and the RBBB pattern. The patient was subsequently digitalized.

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## Role of L-DOPA

(Continued from page 254)

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convention	Delegates Handbook .....	351
	Program .....	418
	Instructional Courses .....	423
	Technical Exhibits .....	428

clinical articles	Teenage maternal mortality in Chicago (1956-1968) <i>Robert E. Lane, M.D. and Murray Brown, M.D.</i> .....	337
----------------------	---	-----

surgical grand rounds	Recurrent duct stones .....	342
--------------------------	-----------------------------	-----

special articles	Doctors of the people, by the people, for the people: A bold proposal for minority recruitment and medical education <i>John Daugirdas</i> .....	346
	Health care delivery crisis <i>Dan Paul Butcher, M.D.</i> .....	349

features	the presidents page .....	317
	obituaries .....	331
	the viewbox .....	341
	the peer reviewer .....	433
	editorials .....	437
	socio-economic news .....	439
	clinics for handicapped children .....	444
	what goes on .....	445
	ekg of the month .....	447
	new pharmaceutical specialties .....	448
	the doctors library .....	449
	practice management .....	450
public affairs .....	451	

(Cover story on page 331)

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REGISTERED



MEDIA DATA FORM



## Emphasize preventive care To stem health crisis

One of the nation's leading educators has called on American medical schools and others concerned with producing health manpower to shift their emphasis to preventive care as a means of bringing the country's health crisis under control.

Joseph Gallagher, M.D. Assistant Vice Chancellor for Health Programs, University of Texas System, speaking at a conference on effective utilization of health care facilities and services sponsored by the Health Insurance Council in Chicago, said that the nation's health systems will not be able to deliver adequate services to the overall population "no matter how much we increase the health manpower," because of misdirected priorities.

"Our present health systems are based primarily on the premise that a person enters the systems only if he or she is sick or injured," he said. "Waiting for a person to get sick or injured before he seeks assistance from our health system or before he can be admitted into the system is not only barbaric, it is not consistent with our accomplishments as a nation.

"If we pursue our episodic illness pattern as the sine qua non in the delivery of health services, we won't be able to afford it."

Dr. Gallagher urged the health professions educational systems and those providing health services to orient their work toward activities which would avoid "spending gigantic sums of money to educate greater and greater numbers of students to lock us deeper and deeper into our present delivery methods."

Among the measures Dr. Gallagher advocated were:

- Maximum use of preventive measures.
- Identification of areas requiring preventive know-how to enable the nation's research capability to focus on it.
- Exploitation of the educational system and the communication media to educate people in preventive health practices, "instead of exclusively emphasizing the glory of hospital medicine, particularly in the sterile whiteness of surgery."

Increasing the emphasis toward preventive health, he said, "would set into motion a method for decreasing episodic illness, even injury" and would be "over the long range far less costly."

**Brief Summary of Prescribing Information—9-9/22/69.** For complete information consult Official Package Circular.

**Indications:** Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

**Contraindications:** Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

**Warnings:** Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

**Precautions:** Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

**Adverse Reactions:** Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

**Usual Dose:** 1 tablet b.i.d.

**Supplied:** Bottles of 60, 600, and 1000 scored 50 mg. tablets.

**Salutensin®**  
hydroflumethiazide, 50 mg./reserpine,  
0.125 mg. protoveratrine A, 0.2 mg.

**BRISTOL** BRISTOL LABORATORIES  
Division of Bristol-Myers Company  
Syracuse, New York 13201



# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### The National Accounts: Uniform Group Coverage

National Account and Central Certification are terms being used more and more frequently among Blue Cross and Blue Shield Plans. A National Account is a group benefit contract which is purchased by a large corporation which has branches throughout the United States and which wishes to offer uniform insurance coverage to all its employees. Central Certification is an administrative system developed to facilitate inter-plan handling of these accounts.

As more large national organizations purchase uniform coverage, the National Account Blue Shield Card will be seen more frequently in the physician's office.

This national identification card differs greatly from the type issued by the Illinois Medical Service. It carries the words "Blue Cross-Blue Shield Identification Card" or "Blue Shield Identification Card" across the top and the words "National Account" or "Central Certification" inside a map of the United States in the upper right hand corner.

The remainder of the card contains the subscriber's name, the employer's name, the plan code of the Control Plan (Home Plan) and the identification number. This number consists of a two or three digit Alpha Prefix and the Control Plan number as the group number and the nine digit social security number of the subscriber as the certificate number (example: AHS-121-235-78-2797). This type of identification number indicates that the account is being handled on a Central Certification basis.

Because of the differences in the kinds of Blue Shield payment benefits among these different groups, it is not always possible for a local Blue Shield Plan to provide the coverage indicated in

the contract. In such a case, payment is made directly to the physician by the Control Plan.

The Illinois Medical Service processes claims for services performed by Illinois physicians for the following national groups:

1. AHS-121 American Hospital Supply
2. ATT-303 American Telephone and Telegraph (Long Lines)
3. KAG-101 Kaiser Agricultural Chemicals  
KAG-601
4. SHW-333 Sherwin Williams Company
5. AV-303 Avis Rent-A-Car

If your patient has one of these identification numbers, complete the Physician's Service Report in the usual manner and send it to us, Illinois Medical Service. Be sure to include the Alpha Prefix in the identification number as this is the primary means of identifying the group as a Central Certification Account.

Should your patient present a National Identification Card which is not one of the above, you should still complete the Service Report in the usual manner and send it to us. If we do not process claims in our own office for that group, we will forward the claim to the correct Control Plan.

### Additional Workshops Set

Additional dinner workshops for Medical Assistants in central and southern Illinois have been scheduled by the Blue Shield Plan of Illinois Medical Service. These workshops are designed to inform Medical Assistants of changes in Blue Shield procedures, benefit structure and methods.

The workshops begin April 1 and continue to the end of June. All Medical Assistants are invited to attend.

The additional dinner workshops are as follows:

April 29	Ramada Inn	Marion
May 5	Ramada Inn	Champaign
May 12	Ranch House	Bureau
May 13	Ramada Inn	Kankakee
May 26	Decatur Club	Decatur
May 27	U.S. Grant Motor Inn	Mattoon
June 2	Holiday Inn	Bloomington
June 3	Ramada Inn	Peoria
June 9	Holiday Inn	Quincy
June 10	Sheraton Inn	Springfield
June 16	Sheraton Inn	Rock Island
June 17	Sheraton Inn	Galesburg
June 23	Henrici's	Rockford



AMERICAN HOSPITAL SUPPLY CORPORATION

PLAN CODE  
121

NAME <b>SEAMAN R. V.</b>
MEMBER IDENTIFICATION <b>AHS 121 243-56-6789</b>

Cut Here

(This is not an advertisement)



## ASK BLUE SHIELD

• • • ABOUT MEDICARE

### L-Dopa Therapy Approved By SSA

In answer to many questions asked by intermediaries, carriers and others, the Social Security Administration has recently defined the eligibility of L-Dopa treatments under Medicare.

L-Dopa, a new drug used in the treatment of Parkinson's Disease, received FDA approval on June 4, 1970.

The Administration has determined that no reimbursement can be made under Part B for the drug L-Dopa itself because it can be self-administered. However, physicians' services rendered in connection with its administration and control of its side effects would be paid under Part B when determined to be necessary and reasonable.

In most cases, L-Dopa therapy could be administered on an outpatient basis with visit frequency ranging from every week to every 2 or 3 months. However, after 6 months of therapy, visits more frequent than once a month would not be acceptable.

Laboratory tests which are considered medically necessary in connection with the control of side effects and the achievement of optimal dosage of L-Dopa include a complete blood count, liver function tests such as SGOT, SGPT, and/or alkaline phosphatase, BUN or creatinine and urinalysis, blood sugar and electrocardiogram.

Should the patient experience reduction in spasticity which would permit the re-establishment of a restorative goal, physician ordered physical therapy services required to enable him to reach this goal would be reimbursable provided these services require the skills of and are furnished or supervised by a qualified physical therapist. However, once a patient's goal is achieved, services necessary to keep him at this level would not generally require the skills of a qualified physical therapist.

Evaluative service rendered during the maintenance level period by a qualified physical therapist in consultation with a physician would be reimbursable as physical therapy. Services furnished by others in connection with carrying out the maintenance program established by the therapist would not be covered.

### SSA Changes In Lab Certification

The Social Security Administration no longer considers the following laboratory certified for Medicare participation:

South East Medical Laboratory  
1832 East 87th Street  
Chicago, Illinois 60617

## New Definitions For Surgical Dressings

The Social Security Administration has revised its definitions of surgical dressings, splints and casts as covered under Medicare.

According to the new definitions, surgical dressings are limited to primary dressings. These are to be therapeutic and protective coverings which are applied directly to lesions either on the skin or opening to the skin and which are required as a result of a surgical procedure performed by a physician.

Items such as ace bandages, elastic stockings and support hose, Spenco boots, leotards and other similar materials are generally used as secondary dressings and, therefore, would not qualify for payment.

Surgical dressings first applied by a physician are covered under Part B as incident to a physician's professional service. Dressings may be reapplied by those other than a physician, such as the patient or a member of the patient's family. When surgical dressings are obtained by a patient on a physician's order from a supplier, the surgical dressing is covered under Part B.

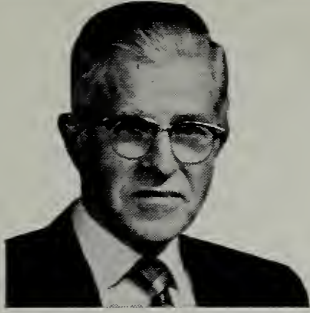
Other items covered as surgical dressings are splints and casts, including dental casts, and colostomy bags and the necessary equipment required for attachment. However, irrigation equipment and supplies used in treating a colostomy condition and dressings required for purposes other than a surgical lesion are not eligible for Part B payments.

## Accepting Assignment Of Partially Paid Bills

A patient may assign, and a physician may accept assignment of, a partially paid bill. In such a situation, the Part B payment will be divided between the patient and the physician.

The physician accepting such an assignment will be paid any eligible amount due under Part B. However, this amount, when added to the amount paid by the patient, can and will not exceed the reasonable charge. Any difference in eligible benefits which is not payable to the physician will be paid to the patient.

Example: A bill for \$300 is presented on which the patient has paid \$100. The reasonable charge for this service is \$300 and \$25 of the deductible has already been met. The total payment due is 80 percent of \$275 (\$300 minus the \$25 remaining deductible), or \$220. Of this amount, \$200 will be paid to the physician (\$300 reasonable charge minus \$100 paid by the patient) and the excess \$20 will be paid to the patient.



## the presidents page

### The Annual Meeting—Our 131st year

On May 16, we will gather together for our Annual Meeting at the Arlington Park Towers Hotel. This beautiful, new hotel, located near the Arlington Park Race Track, is about ten miles northwest of the O'Hare Airport and easily reached by way of the Northwest Tollway.

Since plans are underway to join with the Chicago Medical Society for joint Annual Meetings in the future, this may be the last meeting of the Illinois State Medical Society by itself.

The meeting promises to be one of firsts. The exotic beauty of the hotel, its decorations, and its accommodations should make our meeting superlative in every way.

Except for two meetings held in Springfield, this is the first time in 30 years we have met outside the City of Chicago. It is the first time we have made an effort to incorporate fun, fashion, and frolic along with our pursuit of knowledge, and our serious consideration of progress and policy, in our House of Delegates.

It is the first time we have made a real innovative step forward in continuing education. This is accomplished through our massive self-testing units, supplied by the University of Illinois, and our 36 early morning refresher courses. All this,

of course, is in addition to our usual scientific programs.

It is the first time so many specialty societies have combined with us to hold official meetings. This includes the Illinois Surgical Society, the Society of Obstetrics & Gynecology, the Pediatric and the Allergy Societies. It is the first time all the medical schools will have exhibits, and it is the first time we will face up to the important subject of "human sexuality."

It will be the first time that we will join the two formerly competing dinners on Tuesday night—the Alumni Dinner of the University of Illinois and the President's Banquet—for one big "fun" party. With no speakers' table, no speakers, few introductions, a famous dance band, the incomparable Hildegard and other surprises, who can afford to miss this party?

In order to be assured a room in the hotel and admittance to the refresher courses make your reservations now! ◀

*J. Ernest Breed M.D.*

### Special House of Delegates Session

A Special Session of the Illinois State Medical Society House of Delegates will be held Saturday, May 15, 1971. The call has been issued to address the single item of Foundation for Medical Care proposal.

The session will be held at the Arlington Park Towers Hotel, Arlington Park, and precedes by one day the opening of the Annual Meeting.





The negative power of anxiety

This man thinks his next  
quarrel may be his last.



## Proloid® (thyroglobulin)

**Description:** Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, sodium levothyroxine ( $T_4$ ) and sodium liothyronine ( $T_3$ ). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the sodium levothyroxine and sodium liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of  $T_4$  and  $T_3$  in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

**Indications:** Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

**Contraindication:** Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

**Warnings:** Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid, and dosage should be started at a very low level and increased gradually.

**Precaution:** As with all thyroid preparations this drug will alter results of thyroid function tests.

**Adverse Reactions:** Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

**Dosage and Administration:** Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR,  $T_3$   $^{131}I$  resin sponge uptake,  $T_3$   $^{131}I$  red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of  $T_4$  and  $T_3$  is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

**Instructions for Use:** The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid,  $T_4$  (sodium levothyroxine),  $T_3$  (sodium liothyronine), or  $T_4/T_3$  (liotrix).

Dose of Proloid (thyroglobulin)	Dose of desiccated thyroid	Dose of $T_4$ (sodium levothyroxine)	Dose of $T_3$ (sodium liothyronine)	Dose of liotrix ( $T_4/T_3$ )
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

**Overdosage Symptoms:** Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

**How Supplied:**  $\frac{1}{4}$  grain;  $\frac{1}{2}$  grain; scored 1 grain;  $1\frac{1}{2}$  grain; 3 grain; and scored 5 grain tablets, in bottles of 100 & 1000; and scored 2 grain tablets in bottles of 100.

Warner-Chilcott, Morris Plains, N. J. 07950

## Obituaries

\***David Andelson**, Chicago, died in February at the age of 94. He was a member of the ISMS Fifty-Year Club.

\***N. Louis Campione**, Chicago, died Feb. 11 at the age of 76. He was a member of the ISMS Fifty-Year Club.

\***Otto P. Ehrlich**, Collinsville, died Feb. 11 at the age of 61.

\***J. Gilbert Ellis**, Danville, died Feb. 20 at the age of 66.

\***Robert V. Ferrell**, Eldorado, died Feb. 7 at the age of 58. He was past president and past secretary of the Saline, Pope, Hardin County Medical Society.

\***Carl N. Furness**, Chicago, died Feb. 16 at the age of 70.

\***Gene C. Hamilton**, Mokena, died Feb. 19 at the age of 61.

**Arthur A. Miller**, Ann Arbor, Mich., died Feb. 15 at the age of 49. He was past president of the Chicago Society for Adolescent Psychiatry.

\***Benjamin H. Orndoff**, Park Ridge, died March 6 at the age of 90. He was founder of the Radiology Department at the Loyola University Stritch School of Medicine in 1914. He was a member of the ISMS Fifty-Year Club.

\***Herman J. Pilka**, Highland Park, died Feb. 8 at the age of 73.

\***Jean Stieglitz**, Chicago, died Feb. 6 at the age of 39. She was an anesthesiologist at South Chicago Hospital.

\***Ruth Weyl**, Chicago, died March 1 at the age of 74. She was an associate professor of anesthesiology at the Chicago Medical School and past president of the Illinois Society of Anesthesiologists.

\*Member of Illinois State Medical Society.

### ON THE COVER

By changing the place as well as pace of the 131st Annual Meeting, physicians and their wives will be able to make this Convention something of a "mini vacation" while attending to the business at hand.

Recreational attractions, which include golf, swimming and horse racing at the nearby Arlington Park Race Track can be interspersed with House of Delegates sessions, instructional courses, visits to scientific and technical exhibits and other luncheons and meetings.

The ever-popular President's Banquet, a highlight of Convention, should make your participation in this Convention a most enjoyable one.





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IIMJ  
*Illinois Medical Journal*

# Teenage maternal mortality in Chicago 1956-1968

BY ROBERT E. LANE, M.D. AND MURRAY BROWN, M.D./CHICAGO

## **Deaths from Hemorrhage**

**(Four cases, all with preventable factors)**

### **Case Number 1:**

Age 19 years, single, non-white, G1 P0. A history of no menses for three months was noted. She collapsed and expired at home. The autopsy revealed a ruptured right tubal pregnancy with 1500 cc. of blood in the abdominal cavity.

*Committee judgment:* Obstetric death with preventable factors assigned to patient for lack of prenatal care.

### **Case Number 2:**

Age 18 years, married, white, G1 P0. Uneventful prenatal course. Subject arrived at hospital with vaginal bleeding at 36 weeks gestation, BP of 90/68, pulse 120, no fetal heart tones, transverse lie of fetus. Subject expelled placental tissue. The cervix was partially dilated and an internal version was done with one leg brought through the cervix. Traction was applied for two

hours: Vaginal bleeding subsided and intravenous pitocin was administered. The cervix dilated completely. A breech extraction of a still-born fetus was performed under general anesthesia. Prior to delivery, the subject had received three units of whole blood. Following delivery, the subject bled profusely from the uterus. Manual exploration did not reveal any findings other than atony. The subject developed hemorrhagic shock, was given an additional 4500 cc. of whole blood and six grams of fibrinogen. She remained in shock and expired four hours and 42 minutes after delivery. Autopsy revealed fibrin thrombi in lungs and kidneys, myocardial hemorrhages, petechial hemorrhages of skin, pulmonary edema, bilateral hydrothorax and dilatation of the heart.

*Committee judgment:* Obstetric death with preventable factors of inadequate blood replacement in a patient profusely bleeding, delayed diagnosis of fibrinogen deficiency and adequate therapy of same, and failure to do hysterectomy or other



definitive procedure to control hemorrhage from uterus.

#### Case Number 3:

Age 15 years, single, non-white, G2 P1. First pregnancy terminated by Cesarean section for cephalo-pelvic disproportion. Uneventful current prenatal course. Subject entered hospital at 38 weeks gestation, complaining of pain in the abdomen past 10-12 hours. Cervix partially effaced, closed, cephalic presentation. X-ray pelvimetry revealed inlet contraction (AP of 9.6 cm.). The estimated fetal weight was six pounds. A repeat Cesarean section was advised after the onset of labor. Eight hours after admission, the subject was in shock. During those eight hours, the subject had had complaints of pain at frequent intervals. She was given blood, and taken to surgery, where a laparotomy was performed revealing a ruptured uterus with fetus weighing seven pounds and placenta free in the peritoneal cavity. A total hysterectomy was performed. The subject received a total of 3000 cc. whole blood and expired 60 minutes after the onset of surgery. Autopsy findings were not significant.

*Committee judgment:* Obstetric death with preventable factors of failure to recognize and treat threatening rupture of uterus in a subject near term who had had a previous Cesarean section for cephalo-pelvic disproportion. There was no indication for pelvimetry nor in awaiting the onset of labor.

#### Case Number 4:

Age 17 years, married, non-white, G1 P0. Subject was dead on arrival at a hospital. There was no history of current pregnancy. Autopsy revealed 3500 cc. blood in peritoneal cavity with a rupture of uterus in the fundus. There was marked thinning of the myometrium in the area of the rupture. A fetus weighing 700 grams was free in the peritoneal cavity.

*Committee judgment:* Obstetric death with probable preventable factors assigned to patient for lack of prenatal care.

### Deaths from Infection

(Four cases, two with preventable factors)

#### Case Number 1:

Age 16 years, single, white, G1 P0. Uneventful prenatal course. Admitted to hospital at term with ruptured membranes. A spontaneous labor of eight hours duration, with outlet forceps delivery of normal infant under local anesthesia took place. Subject discharged on third postpartum day after uneventful course. Six days later, she was admitted to the hospital with fever, chills, and pain in the left axilla. Temperature was 103.6F, pulse 126, respirations 26 and foul lochia. Chest X-ray was normal. Cultures of blood and uterus revealed staphylococcus aureus. Subsequent chest X-rays revealed consolidation in right upper lobe of lung. There was no response to antibiotics and supportive therapy. The subject died on the thirteenth hospital day of cardiac arrest. Autopsy revealed staphylococcal septicemia with multiple pulmonary abscesses, subinvolution of uterus with retained secundines and subdural hematoma.

*Committee judgment:* Obstetric death with no preventable factors.

#### Case Number 2:

Age 19 years, married, non-white, G3 P2. Subject was well until two days prior to admission when she used a lysol solution with a bulb syringe for a douche. Following this she developed lower abdominal cramping pain and headache. A fetus was passed at home. Subject arrived at hospital in shock. Adrenalin and levophed brought the blood pressure to 110/70 with pulse of 80. Oxygen was administered. She received blood and intravenous fluids. During this time, subject began coughing, had foamy white sputum and became dyspneic. Moist rales were present in both lungs. A diagnosis of pulmonary edema was made, probably due to over-hydration. A cardiogram showed evidence of myocardial ischemia. Subject was digitalized. Vaginal culture revealed E. coli. A pelvic examina-



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MURRAY C. BROWN, M.D., (right) is Commissioner of Health, Board of Health, in Chicago. Dr. Brown received his M.D. from the University of Virginia, and has been active in the public health field.



tion on admission revealed the uterus to be the size of 7-8 weeks gestation. There was no active bleeding. Subject expired on the third hospital day, after never responding to supportive therapy. Autopsy revealed evidence of induced abortion, acute tubular necrosis of kidneys, pleural and peritoneal effusions, pulmonary edema and myocardial hemorrhages.

*Committee judgment:* Obstetric death with preventable factors of self-induced abortion.

### **Case Number 3:**

Age 18 years, single, white, G1 P0. Subject was admitted to hospital after having had convulsions at home for preceding three days. Subject revealed having had an abortion performed in the home of an unlicensed physician. She stated that he put an instrument in her vagina and told her he couldn't complete the abortion at that time and she would complete it at home. Subject was admitted to hospital with evidence of septic abortion and shock. A curettement was performed. The subject did not improve and expired on the sixth hospital day. Autopsy revealed findings of septicemia from an infected recently pregnant uterus.

*Committee judgment:* Obstetric death with preventable factors assigned to patient and abortionist.

### **Case Number 4:**

Age 17 years, single, non-white, G2 P0. Subject was admitted to hospital with mild irregular pains and slight spotting for past two days. Cervix was dilated to 2 cm., BOW intact and bulging through cervical os. Gestation of 20 weeks duration. Diagnosis of incompetent cervical os. Subject was taken to surgery where a Shirodkar procedure was performed. She subsequently developed sepsis and labor. The Shirodkar sutures were removed. A spontaneous delivery of a macerated fetus by breech presentation occurred. Subject expired two hours after delivery. An autopsy revealed evidence of septicemia with adrenal gland hemorrhage.

*Committee judgment:* Obstetric death with no preventable factors. The committee questioned the obstetric judgment of the person responsible for permitting a Shirodkar procedure be performed on a subject who was not married and who had no absolute evidence of an incompetent cervical os.

## **Deaths from Anesthesia**

**(Two cases, each with preventable factors)**

### **Case Number 1:**

Age 16 years, single, non-white, G2 P1. Past history revealed a vaginal delivery of 6 pound 4 ounce infant after two days of labor, occurring a year prior to current pregnancy. Uneventful current prenatal course. Subject entered hospital at 42 weeks gestation with contractions for preceding four hours, BOW I, cephalic presentation, cervix closed, uneffaced, head at -3 station. After four days of intermittent contractions, she was discharged to her home. Two days later, she re-entered the hospital with regular contractions, cervix was 3 cm. dilated, head at -3 station, BOW I, estimated fetal weight of 4000 grams. After 19 hours of labor, subject was completely dilated with head at -2 station. A diagnosis was then made of cephalo-pelvic disproportion. A spinal anesthetic of 10 mg. of Pontocaine in 1 cc. of 10% dextrose in water and 2 mg. of neosynephrine was administered for Cesarean section. As peritoneum was being opened, the subject stopped breathing. There was no pulse or blood pressure. Cardiac massage was started and ephedrine and adrenalin were given intracardiac. Surgery continued, with the delivery of a 4500 gram infant which required resuscitation for 10 minutes. Subject expired a short time after completion of surgery. No autopsy was performed.

*Committee judgment:* Obstetric death with preventable factors assigned to anesthesiologist regarding the cardiac-respiratory arrest and to the obstetrician for delayed diagnosis of cephalo-pelvic disproportion with delayed definitive therapy of same.

### **Case Number 2:**

Age 16 years, single, non-white, G1 P0. Uneventful prenatal course. Subject entered the hospital in labor, cervix 4 cm. dilated, BOW I, head at -3 station. Pelvimetry revealed an inlet AP of 10.2 cm. and transverse diameter of 11.1 cm. A trial of labor was elected. After 5 hours, the cervix was 7 cm. dilated and the head was at -1 station. The BOW had previously ruptured spontaneously. Six hours after admission, a Cesarean section for cephalo-pelvic disproportion was started under local anesthesia. After delivery of an infant, general anesthesia was instituted. Subject then had emesis, bronchospasm, aspiration, and ventricular fibrillation. She expired 30 minutes after the onset of fibrillation.

*Committee judgment:* Obstetric death with preventable factors of aspiration during general



anesthesia resulting in cardiac fibrillation and arrest.

### **Death from Sickle Cell Disease**

**(One case, no preventable factors)**

#### **Case Number 1:**

Age 18 years, married, non-white, G1 P0. Subject had one prenatal visit two weeks before admission to hospital. She entered the hospital at 36 weeks gestation, complaining of dyspnea and dizziness of one day's duration. A respiratory infection had been present for the preceding three days. The hematocrit was 7%, hemoglobin 2.5 grams, RBC 1,130,000, WBC 17,050 and sickling positive. The laboratory was unable to cross-match blood. Subject expired three hours after hospital admission. No autopsy was performed.

*Committee judgment:* Obstetric death with no preventable factors.

### **Summary Analysis and Conclusions**

The authors' analyses of the above cases reveal the following facts and conclusions regarding teenage maternal deaths:

1. Deaths from pulmonary embolus are primarily unavoidable at the present time. In certain instances of error in obstetric judgment, the pathway may be prepared for the development of a pulmonary embolus.

2. Deaths from air embolus are primarily related to induced illegal abortion and are avoidable.

3. The majority of deaths from toxemia have preventable factors. These preventable factors relate to patient negligence in seeking prenatal care, in following physician orders, or in physician error of judgment in the evaluation of toxemia with resultant delayed definitive therapy.

4. Deaths from hemorrhage are preventable with rare exception. Negligence of the patient in seeking prenatal care with resultant lack of diagnosis of an obstetric complication, and physician error in judgment in the management of an obstetric complication or in his failure to diagnose and adequately treat obstetric hemorrhage, are the predisposing factors or causes for the majority of those deaths.

5. Deaths from infection have preventable factors in approximately half of the cases.

These factors concern patient responsibility in a significant incidence of the cases—through her efforts to obtain a safe illegal abortion—and physician responsibility, frequently through his error of judgment in the conduct of a pregnancy, labor or delivery.

6. Deaths from anesthesia are essentially due to inadequate anesthesia techniques. Obstetric circumstances may ill prepare a subject for anesthesia. However, it is the responsibility of the anesthesiologist to fit the anesthesia method to the status of the subject in order to avoid possible lethal complications of anesthesia.

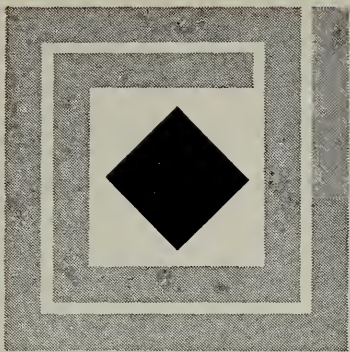
7. The majority of subjects dying from direct or indirect obstetric causes have obstetric complications, which implies that obstetric complications must be diagnosed when present and such subjects with complications be considered high risk obstetric patients with resultant need for more astute obstetric care.

8. The causes of teenage maternal deaths are no different from causes of such deaths in all age groups, nor is the incidence of such causes significantly different.

9. If this retrospective analysis of teenage maternal deaths is representative of that throughout the United States, it may be inferred that the majority of teenage maternal deaths in this country occur in unmarried, non-white young women who presumably are not knowledgeable of contraception or who do not wish to practice contraception. Likewise, it is presumed that such subjects are not sufficiently mature emotionally to cope with the pregnancy, as evidenced by their frequent refusal to seek prenatal care, their non-acceptance of physician orders, and their efforts to seek an illegal abortion.

It, thus, becomes a matter for society in general to assume the responsibility for the underlying causes of the majority of teenage maternal deaths and for the resolution of those causes by creating an environment whereby knowledge and emotional maturity may keep pace with physical maturity.

10. Last but not least is the conclusion that physician awareness to the particular needs of the obstetric patients with complications and his perfect conduct of those pregnancies, labors, and deliveries including consultations when necessary, will add significantly to the lowering of maternal mortality.



## the view box

BY LEON LOVE, M.D./CHAIRMAN AND DIRECTOR, DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

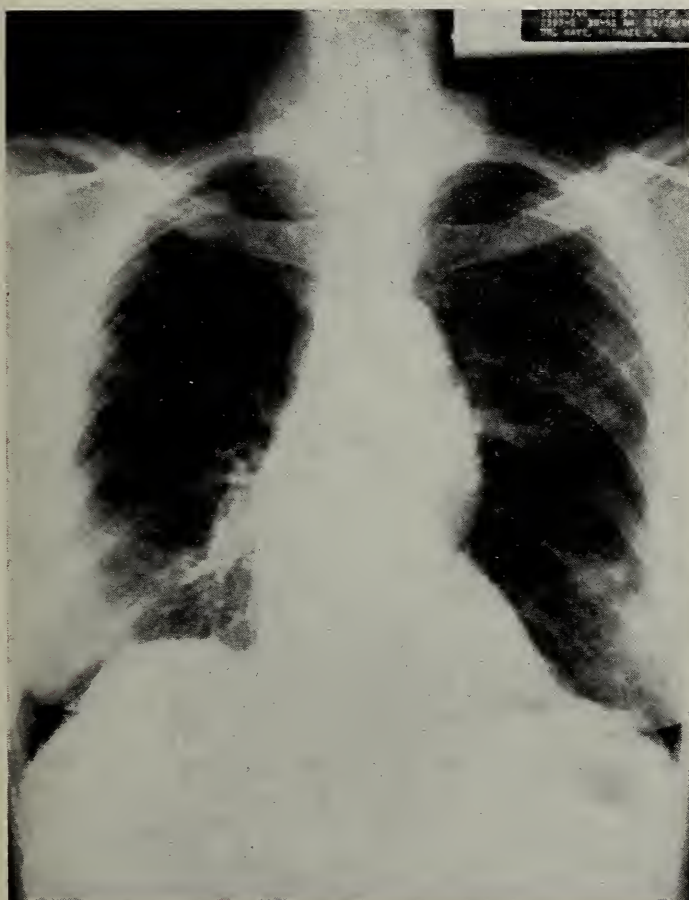


Fig. 1

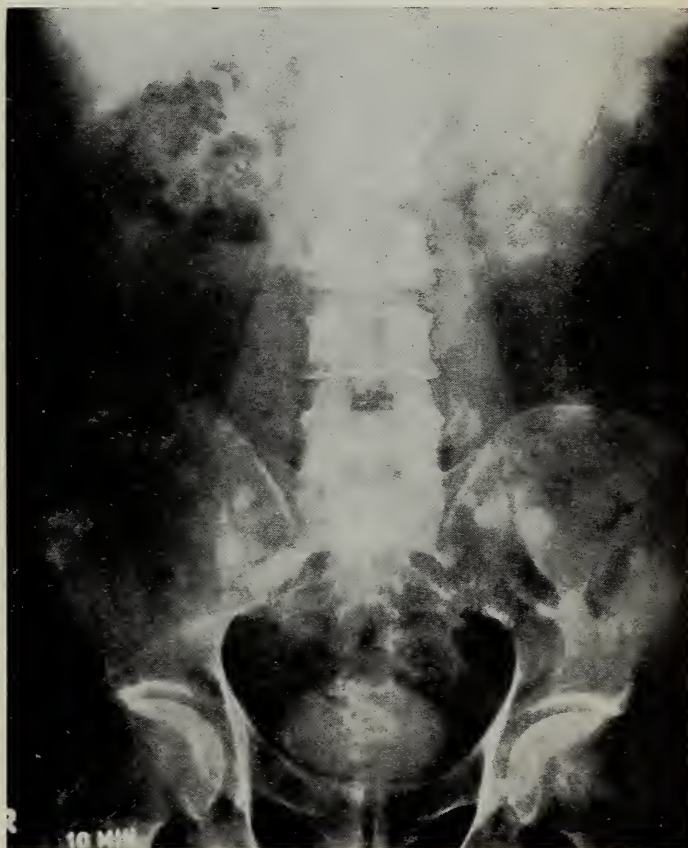


Fig. 2.

A 74-year-old male patient was admitted to the hospital because of pain in the back of increasing severity over the last three or four months. (Fig. 1, 2) What's your diagnosis?

1. Tuberous sclerosis
2. Osteoblastic metastatic disease of bone
3. Urticaria pigmentosa
4. Osteopokolosis
5. Hypervitaminosis A & D
6. Paget's Disease
7. Myelofibrosis

(Answer on page 456)





## surgical grand rounds

# Recurrent duct stones

*Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Chicago Wesley Memorial, Passavant Memorial, and the Veterans Administration Research Hospitals form the basis for the discussions. This case report was part of the Surgical Grand Rounds on February 21, 1970.*

EDITED BY JOHN M. BEAL, M.D./CHICAGO

### Case Report:

**Dr. Dimitri Papachristou:** A 75-year-old female was admitted, complaining of right upper quadrant and epigastric intermittent pain, nausea, vomiting and fever of 24 hours duration. The severe pain radiated to the back and was relieved only by Demerol. Her past history included a cholecystectomy 25 years ago, and common duct exploration for choledocholithiasis and obstructive jaundice six years ago. She had been well for the past six years, except for occasional epigastric distress after heavy meals.

Physical examination showed an icteric color of the skin, deep right upper quadrant tenderness without rebound, absent bowel sounds, and

a temperature of 101°. Urinalysis and white count were normal. Alkaline phosphatase was elevated; SGOT, 654 units; LDH, 500 units; FBS, 250 mgm.%; total bilirubin, 3.5 mgm.% with 0.8 direct. Serum amylase was within normal limits.

Initial treatment included intravenous fluids, antibiotics and nasogastric suction. Operation was performed four days after admission. The common duct was found to be markedly dilated and obstructed by multiple stones and debris. Although Bakes dilators passed readily into the duodenum, the T-tube cholangiogram performed failed to show any dye in the duodenum or evidence of stones. Therefore, the duodenum

was opened and a sphincterotomy performed. Her postoperative course was satisfactory and she left the hospital on the sixteenth postoperative day.

**Dr. Harold Matthies:** An intravenous cholangiogram was ordered for this patient before it was realized that she had a significant degree of jaundice. The common duct did not visualize. When the serum bilirubin exceeds 3 mgm.%, attempts at visualization of the common duct are unsuccessful.

The T-tube cholangiogram taken at the time of operation (Fig. 1) demonstrated a dilated ductal system without evidence of retained stones. The cholangiogram (Fig. 2) which was obtained after operation was satisfactory and the contrast agent entered the duodenum.

**Dr. Juda Jona:** In a publication in 1968, Madden discusses recurrent common duct stones extensively and his point of view of treatment. He urges that the surgeon open the gall bladder at the time of cholecystectomy and classify the stones that he sees. In addition, when he explores the common duct, he must look and decide what type of stone he has found. Madden divides the common duct stones into two groups; the primary stone, one that is developed in the duct; and the secondary stone, which develops in the gall bladder and migrates into the common bile duct. The characteristics of the primary, or stasis, stone (also known as the "earthy stone of Aschoff") are softness when felt between the fingers, and disintegration. Secondary stones are further classified into three major groups; inflammatory, metabolic and combined. The inflammatory stones are multiple yellow faceted stones that usually are the same size and are considered to be the same age. Metabolic stones are divided into pure, pigmented stones which are black and variable in size, calcium bilirubinate stones, known as mulberry stones, and cholestin stones, the very large stones that may erode into the gastrointestinal tract. Therefore, when a stone in the common duct is termed "recurrent," an effort should be made to determine whether it is a primary stone or a secondary stone. Thus, one may be able to distinguish between a "recurrent" and a residual" stone.

Madden, in his series, found that of all common duct stones, 40% occurred in men and 60% in women. Three-quarters of them were about the age of 60. The major symptoms were: pain, 80%; jaundice, 70%; pain and jaundice, 75%. Thus, approximately one-fourth of patients have silent jaundice; which is, jaundice without pain.

Madden found that of all common duct stones in his series, 56% were primary stones. Thirty-seven per cent of the stones were secondary stones, and seven per cent were of the combined variety. Most of the stones that one finds in the common duct are of the primary variety and this has bearing on the treatment.



Fig. 1. Operative cholangiogram taken after removal of common duct stones demonstrates dilated ductal system but contrast age was not present in the duodenum. (Sphincterotomy was performed to correct stenosis of ampulla.)

He also noted that patients with primary stones had the larger common ducts, some of them ranging up to 3 and 4 cm. in diameter, and more than 50% of them had stenosis of the ampulla of Vater. He noted that, on first common duct exploration, 50% of the patients had primary stones. On second exploration, 75% had recurrent primary stones, which is also an important fact concerning our case. Therefore, he concluded that it is very important for surgeons to recognize a primary stone on the first exploration of the common duct and to institute the proper surgical procedure to alleviate this prob-





**Fig. 2.** Cholangiogram which was performed before discharge demonstrates free flow of Hypaque® into the duodenum without evidence of residual calculi.

lem. Choledochoduodenostomy is recommended by him for this problem.

Riedel in 1888, first tried choledochoduodenostomy unsuccessfully. In 1890, Sprengel performed this operation with success. However, this technique was performed seldom until the early 1900's, when Sasse popularized the procedure, which is employed to prevent ascending cholangitis. Madden investigated the validity of this premise in experiments and found that he could not produce cholangitis in dogs by contaminating the common duct content with stool. At the end of his studies, he concluded that ascending cholangitis is really a descending type which occurs only in the presence of obstruction. If one performs a narrow anastomosis or if there is spasm or stricture of the sphincter, one will get cholangitis. He also brings up the fact that it is well known that the duodenal content is relatively sterile and he cannot see a reason why a choledochoduodenostomy should not be employed. In his series, when the anastomosis was made wide enough so that there was no stenosis at the anastomotic site, he obtained very good results.

**Dr. Peter Rosi:** Dr. Jona has reported some of the main features of common duct stones, the most frequent type being the secondary stones that develop in the gall bladder and subsequently enter the common duct. In recent years, the incidence of secondary common duct stones has decreased due to the widespread use of the operative cholangiogram either as a selected or routine procedure during cholecystectomy.

In a comparative review of operative cholangiograms which Dr. Midell and I carried out, there were 392 patients who had cholecystectomy without operative cholangiograms, 19.4% of whom had choledochostomy during which stones were found in 56% of the patients. Secondary stones were found post surgically in seven, or an incidence of 1.7%. There were 521 patients who had a cholangiogram done as a routine procedure during cholecystectomy and the common duct was opened in 14.4% of the patients. Stones were found in 80% of the common ducts explored at surgery. Post surgical follow-up failed to show any residual stones in this group at the time of this study. However, asymptomatic secondary stones may have been subsequently found

following in what appeared to be a negative operative cholangiogram.

The patient discussed today is one of the more unusual types of common duct stone cases with the primary stone. As noted by Dr. Papachristou, the common duct at surgery was dilated to about 15 mm. in diameter and filled with stones, some of which were about 10 to 15 mm. in diameter and seemed to completely fill the lower portion of the common duct. Small, soft stones and debriet (biliary mud) were also found in the common duct. After removal of the stones through a choledochotomy incision, the sphincter of Oddi was dilated up to 5 mm. A 6 mm. Bakes dilator met considerable resistance so that further dilation was discontinued. A T-tube was placed in the common duct through the choledochotomy incision, which was then closed and an operative cholangiogram was taken in order to determine the presence of residual stones and status of the sphincter of Oddi. The first series of films as demonstrated by Dr. Mathies showed a distended duct without any residual stones but no contrast material entered the duodenum. The cholangiogram was repeated by injecting the Hypaque under considerable pressure with twice the amount of solution that was used in the first series. No opaque solution entered the duodenum. The obvious conclusion was that either a stone became impacted in the papilla or there was an achalasia of the sphincter of Oddi. The common duct was reopened and re-explored but no stones were found.

A diagnosis was made of achalasia of the sphincter of Oddi, which we prefer to manage with a transduodenal sphincterotomy. Upon completion of the sphincterotomy, an 8 mm. Bakes dilator was passed through the sphincter without meeting any resistance. The subsequent operative cholangiograms showed the Hypaque solution, which was injected with minimal pressure, entering the duodenum.

The alternative procedure for relief of the obstruction at the sphincter of Oddi would have

been a choledochoduodenostomy which was discussed by Dr. Jona, who also reviewed the recent experimental and clinical studies made by Dr. Madden. Anastomoses of the duodenum to the common duct have been done for obstruction of the lower common duct, such as malignancies in the duct or adjacent viscera or the pancreas and stomach, and for benign lesions such as inflammatory stricture of the papillae of Vater and recurrent common duct stones. A wide anastomosis between the duodenum and common duct that allows free flow of bile into the duodenum is not associated with any demonstrable cholangitis even though the duodenal contents may enter the common duct. Only when the choledochoduodenal anastomosis is narrow, either from an originally performed small anastomosis, or secondarily from a contraction of the anastomosis from recurrent inflammation or fibrosis, does the incidence of chronic cholangitis become a disabling problem.

The majority of patients with residual or primary common duct stones are relieved of their distress with an adequate sphincterotomy. In selected patients with recurrent stones in large common ducts who also have had a previous sphincterotomy, a long longitudinal anastomosis between the common duct and duodenum will give relief of the cholangitis with few, if any, postoperative sequelae.

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#### At the root of inflation

**"Governmental efforts to achieve price stability continue to be thwarted by the continuance of wage increases substantially in excess of productivity gains. Unfortunately, the corrective adjustments in wage settlements that are needed to bring inflationary forces under control have yet to occur. The inflation that we are still experiencing is no longer due to excess demand. It rests, rather, on the upward push of costs—mainly, sharply rising wage rates." —Dr. Arthur F. Burns, chairman, Federal Reserve Board.**



# Doctors of the people By the people For the people

## A bold proposal for minority recruitment and medical education

BY JOHN DAUGIRDAS/CHICAGO

Illinois residents of urban poor communities suffer not only from the general shortage of physicians, but also from maldistribution of the few doctors there are.

For example, a Chicago area study has pointed out that there are more physicians practicing in one suburban medical building than in an entire West Side ghetto of more than 300,000 blacks. In the Kenwood-Oakland area, on Chicago's South Side, the physician-population ratio is 1 to 9000.

Vast tracts of ghetto land in our cities might aptly be described as medical wastelands, where only relics of doctors remain. Forced to see an incredible number of patients a day, the few physicians who do work in these areas are accused of running "production line" practices and of giving cursory and inadequate care.

Schemes for rectifying this maldistribution and supplying doctors to urban poor communities have met with doubtful success. Some have maintained that an inner city practice involves too much of a monetary sacrifice; that to induce doctors to practice in ghetto areas, one needs to

offer them higher pay. Yet the staffing shortage in the inner cities exists despite a payment scale at Office of Economic Opportunity Centers, for example, of \$18,000-\$28,000 a year. It is difficult to envision how higher pay would produce many more urban doctors.

Others advocate the concept of "forgiveness on loans" in exchange for service in specified areas. This idea has been tried as an answer to the shortage of doctors in rural areas. Applied to urban poor communities, the idea is that a medical student practicing in an inner city area for a year or two would "get to like it there." The idea has been tried in Puerto Rico and Mexico, and found to be grossly inadequate. Along similar lines, most clinics in the Chicago area oppose forced rotation of interns and residents through their services.

To still others, it appears that the maldistribution between non-poverty areas and the ghettos will only be corrected after the former become saturated with doctors. Only then, following the laws of supply and demand, will physicians practice in the inner city. "More medical schools!" is the cry of this group. However, increased numbers of doctors per se will not solve the problems of the urban poor communities for some time to come.

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**JOHN DAUGIRDAS** is in the six-year medical program at Northwestern University, Class of 1973. He is also working on a Ph.D. in psychology, and has been active in free clinics in the Chicago area. Daugirdas developed the Urban Doctors Program together with minority recruitment directors in the Chicago area.

The hard facts are that few physicians have chosen to practice in urban poor communities. They can neither be bought nor coerced into doing so. It becomes increasingly clear that quantitative changes are not enough. What is needed is a *qualitative* change in the type of physicians the medical schools are producing. To bring about such a qualitative change, a committee of students and faculty at Northwestern University Medical School has proposed an Urban Doctors Program.

The authors of the Urban Doctors Program maintain that the best physician for an urban poor community would be a person who comes from that community. Such a physician could speak the language of the community. He could better communicate with its patients and better identify with their needs.

With these factors in mind, the goal of the Urban Doctors Program is to foster health care for the urban poor by providing indigenous physicians to the poverty communities of Chicago.

The program proposes to identify well-motivated high school graduates from these communities, to further their education for two or three years at a community college, and to secure admission to a Chicago medical school for those who have completed this training. By helping participants maintain existing social and emotional ties during the long process of becoming a physician, the program will encourage potential doctors to remain members of their original community.

Maintenance of long-standing neighborhood ties will be facilitated by utilizing local institutions for both premedical and medical training, thereby minimizing physical and cultural dislocation. Community orientation will be further reinforced by a curriculum emphasizing urban health needs and by a continuing relationship of UDP students with health services in their areas.

Locally oriented by its very nature, the program is being developed as a pilot project. It will serve as a model for all cities that contain poor communities.

The Urban Doctors Program will in no way coerce the students into practice in urban poor communities, by means of forgiveness on loans nor by any other means. What the program will do is minimize the displacement of people. One will no longer need to speak of returning to the community; the UDP students will always maintain contact with their communities.

The first two years of the program will be at a community college to which the students will commute. There will be no displacement from the community during this period. The students will have the option of living at home during the medical school years of the program, though they will not be encouraged to do so. In either case, dislocation from the community will be at most, a matter of a half-hour subway ride. In this way, existing social and emotional ties between the students and their communities will be preserved.

UDP students will maintain contact with clinics in their neighborhoods by means of site visits, "rap sessions" with staff, and work experience at paraprofessional and then professional levels. The curriculum of the program concerning urban health care will emphasize both theory and actual "field work" in the community. This field work may take the form of performing health surveys, training paramedical personnel, or working with physicians practicing in the inner city.

As the training of a UDP student progresses, he will be able to take on increasing amounts of medical responsibility in the health care delivery system in his community until he is finally ready to assume the role of an urban doctor.

Aside from the concepts of regional recruitment and continued contact with community health services, the Urban Doctors Program incorporates several other features which may have widespread implications. The first is the principle of guaranteed admission to medical school to high school graduates. A participating medical school will grant a candidate admission to the program with the understanding that a place in the medical school will be reserved for him, providing he performs in the premedical part of the program to the medical school's satisfaction.

The Urban Doctors Program idea is also attractive to those who advocate group practice in the inner city. In the course of their medical education, the UDP students will establish close social and professional ties with each other and with other students in medical school. Group practices in the Chicago area, involving both UDP and non-UDP students, are the logical extension of these ties.

Funding for the UDP will include all tuition and costs for the six years of the program. These funds should be obtained from sources separate from those that medical schools normally use for scholarships and loans. This is to insure that: (1) funds will not be taken from the present scholarships and loans of other students in medical school; (2) all medical schools in the Chicago



area could participate regardless of their financial situation; and (3) UDP students will be taken in addition to, and not in place of, minority students admitted through normal channels. Preliminary estimates set the total cost of the program at \$35,000 per UDP physician.

To recapitulate, the purpose of the Urban Doctors Program is to supply indigenous physicians to the poverty communities of Chicago. The authors of the program have recognized that all medical schools in the Chicago area share in this responsibility and that coordination of individual effort is necessary. The option for such cooperation is built into the Urban Doctors Program.

Only one medical school is required to initiate the program. Its responsibility will consist of the following: (1) serving on the Admission-Promotions Committee; (2) guaranteeing admission to all students of the program who have successfully completed their premedical training; and (3) helping to develop and teach the premedical curriculum.

All medical schools in the Chicago area will be encouraged to enter into similar contractual

agreements with the program. The community college chosen for the premedical phase of the program, Central YMCA Community College, is not directly affiliated with any one medical school. The physical location of the College is also such that it would not tend, a priori, to associate with one medical school more than another. Thus, such a community college provides the foundation for a comprehensive program involving all the medical schools in the Chicago area.

Whereas the first entering class (planned for September, 1972) has been tentatively set at 25, this number will, of course, expand as inter-institutional cooperation becomes a reality. Ultimately, the authors envision funding at a level of several million dollars, involving five medical schools and graduating well over 100 indigenous physicians a year.

Northwestern University is presently exploring potential sources of funds for the program. Government agencies and foundations are being approached while the details of the program are being worked out.

(Reprinted from *The New Physician*, November, 1970, with permission)

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## ***Genetic manipulation: A means of conquering hereditary diseases***

New means of conquering hereditary diseases through genetic manipulation will be a forerunner in basic medical research during the next decade, according to the National Society for Medical Research. "The effects of genetic alteration upon such diseases as diabetes, hemophilia, and certain emotional disorders may be under study in sophisticated and promising stages of laboratory animal experimentation by 1980," they said, "which will provide the platform for further advances in the future."

Citing recent studies by Dr. Bernard D. Davis of Harvard, the group noted major deterrents to the application of genetic control over such human traits as intelligence, temperament and physical structure lie in differences between "monogenic" and "polygenic" traits. Monogenic traits, such as eye color and various hereditary diseases, result from genes which individually exert an all-or-none control over the trait. Polygenic traits depend on multiple genes and thus vary continuously rather than in an all-or-none

manner. "Even if scientists eventually develop the ability to incorporate genes into human germ cells, and thus repair monogenic defects, we would still be far from transferring the large blocs of genes needed to specify highly polygenic behavioral traits," reported Dr. Davis.

Another deterrent is that differences in behavior depend very much on differences in the wiring diagrams of our individual brains, and added genes could not be expected to influence this wiring diagram unless put into the germ cell before development. In contrast, a gene for supplying a missing product, such as insulin, could conceivably be effective whether introduced into a germ cell or into a fully developed individual.

"Education on the distinctions between monogenic and polygenic inheritance is of extreme importance if the public is to distinguish between realistic and wild projections for future developments in genetic control in man," the Society explained.

# Health care delivery crisis!

*Address presented before the DuPage County Medical Society, December 16, 1970.*

Dramatic changes will occur in the health industry in the United States within the next few years: Third party carrier intervention between patient and physician will become an increasingly larger factor in medicine; governmental controls, over cost, as well as quality and quantity of medical care will become a fact of life for physicians; and the issue of health care delivery will continue to be a major political issue.

Fantastic growth in the health care industry will continue on an upward trend within the next decade, with an estimated cost rise from \$65 billion to \$100 billion by 1975, with 5.5 million people employed in the health field.

Last year, Medicare and Medicaid costs alone were about \$9 billion. Projected costs for various national health programs range from \$15.4 billion for AMA tax credit scheme to \$50-70 billion or more for the plans proposed by U.S. Senators Javits and Kennedy.

The physician is no longer idealized as was the country doctor of the early 1900's.

A recent Harris Poll revealed that patients have mixed feelings about physicians: although 78% expressed a high regard for their own personal physicians, most had long lists of complaints about services and charges.

• 63% of the public felt "doctors try to jam so many

patients into office hours, they don't give enough time and attention to anyone."

• 62% said "no doctor who refuses to make house calls can be called conscientious."

• 55% felt that "modern medicine is so specialized the general practitioner is just a referral service."<sup>2</sup>

Ralph Nadar and his group have called for the establishment of quality control standards for doctors reflecting the increasing public concern and loss of the physician's image. Nadar deplores the "almost complete lack of internal quality controls in the medical profession, which has allowed a large measure of very poor medicine to be practiced."

Nadar also reported that medicine is not protecting the public from incompetent physicians, that licensure requirements are inadequate and outdated, and that "medical societies were guilty of not pressuring doctors to take refresher courses."<sup>3</sup>

While many of Nadar's comments are without reasonable basis, some recommendations have merit and unfortunately, will have a measurable propaganda effect not favorable to the physician.

Recently, the Chicago Medical Society came under fire in a *Chicago Tribune* editorial of November 9, 1970, because of the lack of willingness to provide emergency service for people who have no family physician. The editorial concludes with a cogent comment:

"Something is wrong when medical education is being subsidized more and more by the public while young doctors seem to be less and less willing to render any services in return. We hope the medical societies themselves can figure



Dan Paul Butcher, M.D., maintains a private practice in radiology and is associate radiologist at Memorial Hospital of Dupage County, in Elmhurst. Dr. Butcher received his M.D. from Northwestern University Medical School, and is a Diplomate of the American Board of Radiology. He is also a member of the American College of Radiology and the Radiological Society of North America, and the current president of the DuPage County Medical Society.



## "The foundation concept seems to be gaining support . . . ."

out a way to remedy this inequity. Because if they don't, the chances are that the government will do something about it—and whatever the government does is likely to be less efficient and more costly to all of us than what the doctors themselves might devise."<sup>4</sup>

The key words in that last paragraph of the editorial—"whatever the government does is likely to be less efficient and more costly to all of us than what the doctors themselves might devise" must be emphasized because the physicians today know from first-hand experience how inefficient governmental medicine really is. Consider the Veterans' Administration, the military organization, excessive costs, and the lack of a personal patient-physician relationship.

Recently, the Illinois State Medical Society held a leadership conference concerning "Health Care Delivery Changes in the '70's" which was well attended. National authorities, such as the Assistant Secretary of the Department of Health, Education and Welfare, Dr. Roger O. Egeberg, and others, commented repeatedly on the urgency of health care delivery problems. It became self-evident that unless private enterprise assumes an important and constructive leadership in solving the so-called crisis of health care delivery, "big brother" government will take over, and medicine as we know it will no longer exist.

What are some of the solutions currently being offered to solve the health care delivery crisis?

The Under Secretary Elliot

Richardson, HEW, is striving to preserve a "pluralistic base for this nation's health care delivery system."<sup>5</sup> Dr. Egeberg, Assistant Secretary for Health predicted the following:

"1. A greater expansion of alternatives to health care other than hospitalization.

2. Enrollment of more Americans in prepaid programs providing comprehensive family care on a more continuous basis.

3. A very great increase in neighborhood health facilities with a full range of health services that can be rendered outside the hospital.

4. A sharp increase in the number and variety of allied health professionals."

Egeberg expects a "shift away from the cost-plus reimbursement formula to something that will encourage efficiency and help the health care dollar do more."<sup>6</sup>

What this seems to mean is government-funded or aided experimental programs to provide care through health maintenance organizations (HMOs) or foundations for medical care (FMCs). The foundation concept seems to be gaining national support on the basis of the premise that control by physicians is preferable to control by governments, committees, boards, consumers, etc.<sup>7</sup> California leads the foundation parade with 16 and many other states are following suit.

Speaking generally FMCs or HMOs would be sponsored by State or local medical organizations or possibly other non-medical or partly medical organizations such as medical schools. A whole package of medical care would be offered

by the FMC or HMOs to all patients in the local area, indigent or otherwise, for a fixed, annual, *prepaid rate*—including office and hospitalization care. For the elderly, the Federal government would pay 95% of what it would cost to cover each individual's care under Medicare Parts A & B. Patients would contract with the FMC for prepaid care on a yearly basis. Physicians would also contract with the FMC to take care of these patients, probably, (or hopefully!) on a fee-for-service basis in the private office with the bill simply sent to the FMC for contract patients—Co-insurance and deductible amounts would probably be utilized for economy.

The key to successful HMO operation in the *Bennett (R. Utah) amendment*, which has recently been adopted by the Senate Finance Committee, is the *PSRO or Professional Standards Review Organization*. The Bennett amendment "provides for peer review of Medicare and Medicaid operations through foundations or other groups formed by state or local medical societies if they are willing."<sup>8</sup>

Cost and quality of services will be continuously reviewed by local physicians serving on the peer review committee. Only those fees exceeding maximums set by the local physicians will be subject to review.

One state medical society, Pennsylvania, has recently voted to begin a type of HMO, a foundation, which will be open to their 12,000 members and all their patients. The stated aim is to develop pre-

(Continued on page 452)



MAY 16-19, 1971 • ARLINGTON PARK TOWERS HOTEL • ARLINGTON HEIGHTS

# DELEGATES HANDBOOK



# INDEX

## HOUSE OF DELEGATES

Agenda .....	356
Board of Trustees .....	353
Committees .....	358
Delegates and Alternates .....	354
Ex-Officio Members .....	353
Officers .....	353

## OFFICERS AND ADMINISTRATION

President .....	361
President-Elect .....	362
First Vice-President .....	362
Second Vice-President .....	363
Trustee Reports	
First District .....	363
Second District .....	363
Third District .....	417
Fourth District .....	363
Fifth District .....	364
Sixth District .....	364
Seventh District .....	364
Eighth District .....	365
Ninth District .....	365
Tenth District .....	365
Eleventh District .....	366
Trustee-at-Large .....	366
Chairman of the Board .....	366
Executive Administrator .....	367
Speaker of the House of Delegates .....	367
Vice-Speaker .....	367
AMA Delegation .....	368
President of the Woman's Auxiliary .....	371
Committees of the Board of Trustees	
Advisory Committee to the Woman's Auxiliary .....	372
Committee on Constitution and Bylaws .....	373
The Educational & Scientific Foundation .....	374
Committee to Study Osteopathic Problems .....	375
Committee on Health Care Financing .....	375
Policy Committee .....	375
Publications Committee .....	376
Editorial Board .....	377
Editor <i>Illinois Medical Journal</i> .....	378
Task Force on Comprehensive Health Planning .....	379
Task Force on Physician Shortage and Services to Medically Deprived Areas .....	379

## ECONOMICS AND PEER REVIEW

Council on Economics and Peer Review .....	382
Sub-Committee on Drugs and Therapeutics .....	386

## EDUCATION AND MANPOWER

Council on Education and Manpower .....	387
---	-----

## ENVIRONMENTAL AND COMMUNITY HEALTH

Council on Environmental and Community Health .....	391
---	-----

## FINANCES AND BUDGETS

Secretary-Treasurer .....	398
Sub-committee on Benevolence .....	402

## LEGISLATION AND PUBLIC AFFAIRS

Council on Legislation and Public Affairs .....	403
---	-----

## MEDICAL-LEGAL

Medical-Legal Council .....	407
Ethical Relations Committee .....	408

## MENTAL HEALTH AND ADDICTION

Council on Mental Health and Addiction .....	409
--	-----

## PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Council on Public Relations and Membership Services .....	412
--	-----

## SOCIAL AND MEDICAL SERVICES

Council on Social and Medical Services .....	414
--	-----

## SPECIAL REPORTS

Illinois Department of Public Aid .....	383
Illinois Department of Mental Health .....	410
Illinois Department of Public Health .....	393
Illinois Division of Vocational Rehabilitation .....	384
Resolutions .....	416
Program Summary by Days .....	418
Program by Subject .....	420
Instructional Courses .....	423
Scientific Exhibits .....	427
Technical Exhibits .....	428

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President Elect .....	L. T. Fruin
Secretary-Treasurer .....	Jacob E. Reisch
Speaker of the House .....	Paul W. Sunderland
(Vice Speaker—when presiding)	

## TRUSTEES

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Second District .....	Wm. A. McNichols Jr.	1971	Sixth District .....	Mather Pfeiffenberger	1972
Third District .....	Wm. M. Lees	1971	Seventh District .....	Arthur F. Goodyear	1973
	Frank J. Jirka Jr.	1971	Eighth District .....	Eugene P. Johnson	1973
	Warren W. Young	1972	Ninth District .....	Charles K. Wells	1972
	Fredric D. Lake	1972	Tenth District .....	Willard C. Scrivner	1972
	James B. Hartney	1973	Eleventh District .....	Joseph R. O'Donnell	1971
	Frederick E. Weiss	1973	Trustee-at-Large .....	Edward W. Cannady	
Fourth District .....	Fred Z. White	1973			

## EX OFFICIO

(Privilege of the floor but without the right to vote)	
1st Vice President .....	George Shropshire
2nd Vice President .....	C. J. Jannings III
Vice Speaker (when not presiding) .....	Andrew J. Brislen

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Edward W. Cannady .....	1970	Willis I. Lewis .....	1954
Everett P. Coleman .....	1945-46	George F. Lull .....	1963
Newton DuPuy .....	1968	Burtis E. Montgomery .....	1966
Harlan English .....	1964	Edward A. Piszczek .....	1965
Edwin S. Hamilton .....	1962	Caesar Portes .....	1967
H. Close Hesseltine .....	1961	Leo P. A. Sweeney .....	1953
James H. Hutton .....	1940	Philip G. Thomsen .....	1969
		Arnell M. Vaughn .....	1955

## Delegates to AMA

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Carl E. Clark	Maurice M. Hoeltgen	Harold A. Sofield
Harlan English	Joseph R. Mallory	Philip G. Thomsen
Theodore Grevas		Francis W. Young

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George A. Hellmuth .....	Third District	Paul P. Youngberg .....	Fourth District

## Officers of AMA

Walter C. Bornemeier .....	President—AMA
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# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

<i>County</i>	<i>Delegate</i>	<i>Alternate</i>	<i>County</i>	<i>Delegate</i>	<i>Alternate</i>
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ALEXANDER	Lewis S. Ent	Chas. L. Yarbrough	MACON (2)	Maurice D. Murfin	Clarence G. Glenn
BOND	Boyd McCracken	Kenneth Kaufmann		Carl L. Sandburg	A. J. Kiessel
BOONE	Joseph Baum	James B. Ellis	MACOUPIN	Lee L. Johnson	Robert H. Rutherford
BUREAU	Louis Lukancic	Donald Gallagher	MADISON (2)	Edward K. DuVivier	James Adams
CARROLL	L. B. Hussey	E. M. Colli		Willis W. Bowers	George F. Dietz
CASS-BROWN			MARION	W. P. Plassman	W. W. Davidson
CHAMPAIGN	Clarence Walton	Richard Schaede	MASON	Jack Means	Dario Landazuri
	Harold Kolb	James Laidlaw	MASSAC	George Green	none
CHRISTIAN	Frederick W. Siegert	R. M. Seaton	McDONOUGH	Donald H. Dexter	V. B. Adams
CLARK	Eugene P. Johnson	George T. Mitchell	McHENRY	George Alvary	Edward Chereck
CLAY	Fred Cycholl		McLEAN	Paul Theobald	G. B. McNeely
CLINTON	J. R. Sosa	W. L. DuComb	MENARD	Robert J. Schafer	Paul Purdy
COLES-			MERCER	M. E. Conway	Monty P. McClellan
CUMBERLAND	Joseph R. Mallory	M. W. Hollowell	MONROE	Edilberto Maglasang	Joseph A. Werth
CRAWFORD			MONTGOMERY	R. E. Sommer	N. K. Floreth
DEKALB	John Ovitz	John Ladd	MORGAN-SCOTT	Robert R. Hartman	E. C. Bone
DEWITT	George E. Castrovillo	John Sellett	OGLE	Rudolph W. Ziegler	L. Roy McDaniel
DOUGLAS	W. G. Steiner	G. A. Jones	PEORIA (3)	G. W. Giebelhausen	Fred J. Heinzen
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	Morgan M. Meyer	Charles G. White		Marcus Everett	Donald Anderson
	James P. Campbell	Ralph G. Ryan	PERRY	C. E. Cawvey	James B. Stotlar
	J. P. Schweitzer	Lily Ann Palmer	PIATT	Marion D. Kinzie	William Mundt
	William E. Hill	William C. Perkins	PIKE	Myer Shulman	Gene Goodman
EDGAR	J. M. Ingalls	Joseph R. Shackelford	PULASKI	A. L. Robinson	Marvin F. Powers
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FAYETTE	Stanley W. Moore	L. G. Oder	ROCK ISLAND	Theodore Grevas	George H. Burke
FORD	Ross N. Hutchison	Edson L. Etherton		C. P. Cunningham	Billie H. Shevick
FRANKLIN	John P. Pope	Harry Lewis	ST. CLAIR (3)	Wm. Walton	John S. Hipskind
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HAMILTON			STEPHENSON	E. L. Vickery	Jamie O. Ballesteros
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CALHOUN			UNION		
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KANE (3)	James McDonald	Gerald J. Liesen	WABASH	T. R. Young	Ernest Lowenstein
	Wayne N. Leimbach	Peter J. Starrett	WARREN	Russell Jensen	K. Ambrose
	Robert G. Stone	A. Beaumont Johnson	WASHINGTON	J. L. Beguelin	Charles W. Longwell
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KENDALL			WHITE	Phillip D. Boren	
KNOX	John J. Holland	Homer L. Fleisher	WHITESIDE	John F. Hubbard	C. L. Mueller
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	Earl Klaren	Richard Dolan		Robert J. Becker	John H. Kendall
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				Donald H. Wrork	Robert D. Weber
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					Hans W. Riggert

# CHICAGO MEDICAL SOCIETY

## Delegates

## Alternate Delegates

## Delegates

## Alternate Delegates

### AUX PLAINES BRANCH

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Roland Kowal	Arthur G. Lawrence
Allison L. Burdick, Sr.	Gustave A. Hemwall
Everett E. Nicholas	Richard H. Blankshain
John S. Hyde	Allison L. Burdick, Jr.
Charles J. Weigel	Chester B. Thrift
C. Otis Smith	Michael J. Parenti
William Ashley	Matthew Platt

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Stanley E. Ruzich	Paul M. Blackburn
Robert E. Lee	Nestor S. Martinez

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Raymond Nemecek	Miles Cermak
Edward A. Razim	Donald S. Miezio
Colman J. O'Neill	Robert F. Cesafsky
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Frank C. Kwin	Joseph A. Patka
Frank J. Saletta	Kosme F. Kapov
William Nainis	John E. Meyer
(entitled to one more Delegate and Alternate)	

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Harold C. Lueth	Willard A. Fry
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James W. Ford	James R. Dillon
Leon L. Ampel	Harley M. Sigmond
Richard Stalzer	Carl H. Johner
Philip Sheridan	Myles P. Cunningham
William J. FitzPatrick	Jerome T. Paul
John W. O'Donnell	George McDermott

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Arthur T. Haebich	Frank J. Haufe
Vincent C. Sarley	Philip H. Heller
Alfred J. Faber	Karl H. Siedentop
Eugene Broccolo	Thomas J. Conley
Lawrence Hirsch	Sanford Franzblau
George Holmes	Theodore Johnson
Allen Hrejsa	Alexander N. Ruggie
Martin P. Meisenheimer	Herman Wing

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David S. Fox	Mathew W. Kobak
Loran H. Dill	Henrietta Herbolzheimer
Charles P. McCartney	Harry L. Hunter
Myron M. Hipskind	Daniel J. Pachman
Murry M. Paull	Eugene F. Lutterbeck

### NORTH SHORE BRANCH

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Burton J. Soboroff	Danforth Chamberlain
Clarence A. Norberg	Joseph H. Skom
Philip R. McGuire	H. Kenneth Scatliff
Herschel Browns	Samuel T. Gerber
George C. Markoutsas	Lief Bjornssen
Joseph R. DeCaro	Rudolph W. Roesel
William O. Ackley	William B. Stromberg, Jr.
Frank M. Quinn	Frank Hussey
John B. Murphy	Jack D. Clemis
David T. Petty	Steven J. Spinuzza

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Roland R. Cross, Jr.	Daniel Ruge
Samuel L. Andelman	C. Larkin Flanagan
William A. Hutchison	Bernard T. Peele
Coye C. Mason	Ray Silins
Vincent C. Freda	Richard A. Perritt
Jack Williams	Benjamin F. Lounsbury
Erwin M. Patlak	I. Pat Bronstein
Clifton L. Reeder	Joseph Schifano
James P. FitzGibbons	Lydia Nikurs

### NORTHWEST BRANCH

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E. J. Kotanyi	N. J. Kupferberg
Michael J. Kutza	M. A. Rydelski
I. P. Lombardo	John M. Smialek
Alfred A. Zanette	J. V. Fowler, Jr.

### SOUTH CHICAGO BRANCH

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Simon Y. Saltman	Maynard I. Shapiro
Arne E. Schairer	Anthony G. Cesare

### SOUTH SIDE BRANCH

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Robert R. Mustell	Maurice Gleason
Kermit T. Mehlinger	Otto J. Keller

### SOUTHERN COOK COUNTY BRANCH

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Herbert E. Fisher	Clarence R. Heidenreich
Charles Caul	Robert Van Etten

### STOCK YARDS BRANCH

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### WEST SIDE BRANCH

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Anna Marcus	Henry D. Okner
J. Robert Thompson	Louis S. Varzino

### AT-LARGE

Francis W. Young
Ralph E. Dolkart
William E. Adams
Charles P. McCartney
Fred A. Tworoger



# Agenda

## 1971 House of Delegates

PAUL W. SUNDERLAND, *Speaker*

ANDREW J. BRISLEN, *Vice-Speaker*

### FIRST SESSION

3 p.m., Sunday, May 16, 1971  
Arlington Park Towers, Arlington Heights

1. Call to order by the Speaker—Paul W. Sunderland
2. Invocation
3. Roll call  
Report of the Committee on Credentials  
Edward DuVivier
4. Report of the Committee on Rules & Order of Business  
Myer Shulman, *Chairman*
5. Approval of the minutes of the May, 1970 meeting of the House of Delegates (Abstracts enclosed in packet for members of the House)
6. Remarks of the Speaker—Paul W. Sunderland
7. Memorial service for members of ISMS who have died since May, 1970  
Conducted by Jacob E. Reisch, *Secretary*
8. Introduction of new delegates  
Paul W. Sunderland  
Introduction of SAMA members in the House
9. Remarks by the President of the ILLINOIS MEDICAL ASSISTANTS ASSOCIATION  
Jean Berschinski, *President*  
(Escorted to podium by Dr. Philip G. Thomsen)
10. Report to the House of Delegates  
Mrs. Wilson West, *President*  
Woman's Auxiliary to the ISMS  
(Escorted to the podium by L. T. Fruin, *President-Elect*)
11. Introduction of officers of other state medical societies and honored guests  
J. Ernest Breed, *President*
12. Introduction of AMA delegates & alternates from ISMS  
H. Close Hesseltine, *Chairman* of delegation
13. Presentation of AMA-ERF check to the representative of the Illinois medical schools by  
J. Ernest Breed, *President*
14. IMPAC (Illinois Medical Political Action Committee) report by  
Philip G. Thomsen, *Chairman*
15. President's Address  
J. Ernest Breed, *President, ISMS*
16. Report to the House  
Roger N. White, *Executive Administrator*
17. Presentation of the 1971 Edwin S. Hamilton Teaching Award of the Interstate Postgraduate Medical Association
18. Introduction of supplementary reports not included in the packet
19. Announcement of changes in Reference Committee personnel
20. Introduction of resolutions and referral to correct Reference Committees by the Speaker
21. New business and announcements
22. Recess until 2 p.m. on Tuesday, May 18, when the House will hear reports of Reference Committees

## SECOND SESSION

2 p.m., Tuesday, May 18, 1971  
Arlington Park Towers, Arlington Heights

1. Call to order by the Speaker—Paul W. Sunderland
2. Roll call
  - Report of the Committee on Credentials
  - Edward DuVivier
3. Report of the Committee on Rules & Order of Business
  - Myer Shulman, *Chairman*
4. Announcement of the recipients of the Scientific Exhibit Awards
  - J. Robert Thompson, *Director of Scientific Exhibits*
5. Introduction of officers of other state medical societies and honored guests
  - J. Ernest Breed, *President, ISMS*
6. Reports of Reference Committees:
  - a. Constitution & Bylaws
    - A. Everett Joslyn, *Chairman*
  - b. Officers & Administration
    - Joseph R. DeCaro, *Chairman*
  - c. Finances, Budgets & Publications
    - Morgan M. Meyer, *Chairman*
  - d. Legislation & Public Affairs
    - James Fitz Gibbons
  - e. Education & Comm. Health Services
    - Barry Seng, *Chairman*
  - f. Economics & Social Services
    - Edward A. Razim
  - g. Public Relations & Misc. Business
    - Jack Means, *Chairman*
7. Unfinished business
8. New business
9. Recess until 10 a.m. Wednesday, May 19, 1971

## THIRD SESSION

10 a.m. Wednesday, May 19, 1971  
Arlington Park Towers, Arlington Heights

1. Call to order by the Chairman—Paul W. Sunderland
2. Roll call
  - Report of the Committee on Credentials
  - Edward DuVivier
3. Report of Committee on Rules & Order of Business
  - Myer Shulman, *Chairman*
4. Introduction of officers of other state medical societies and honored guests
  - J. Ernest Breed, *President, ISMS*
5. Recognition of Walter C. Bornemeier
  - President of A.M.A.
6. Induction of L. T. Fruin, *President-Elect*, into the office of President of the Illinois State Medical Society
  - J. Ernest Breed, *Retiring President*
  - OATH OF OFFICE:
 

"I, L. T. Fruin, do solemnly swear that I will abide by the Principles of Medical Ethics of the American Medical Association and by the policies of this House of Delegates and that I will work toward the improvement of the practice of medicine and the care of the sick in Illinois."
  - Presentation of the President's Medallion to Dr. Fruin
  - Dr. Breed
7. Remarks of the President—L. T. Fruin
8. Presentation of the remaining reference committee reports
9. Elections
  - Report of the nominating committee
  - a. President Elect (Chicago)
  - b. 1st Vice President (Downstate)
  - c. 2nd Vice President (Chicago)
  - d. Secretary-Treasurer (Downstate)
  - e. Speaker of the House (Downstate)
  - f. Vice Speaker (Chicago)
  - g. Trustees:
 

<i>District</i> 1st 2nd 3rd	<i>Terms Expiring</i> Joseph L. Bordenave William A. McNichols, Jr. William M. Lees Frank J. Jirka, Jr.
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- If new Bylaws go into effect
  - 1 for a one year term to 1972
  - 1 for a two year term to 1973
  - 1 for a three year term to 1974
- 11th District
  - Joseph R. O'Donnell
- h. Delegates to AMA
  - To take office Jan. 1, 1972 and serve to Dec. 31, 1973
- Terms expiring:
  - Edward A. Piszczek
  - Harold A. Sofield
  - Philip G. Thomsen
  - Harlan English
  - Edward W. Cannady
  - Theodore Grevas
- i. Alternate delegates to AMA
  - To take office Jan. 1, 1972 and serve to Dec. 31, 1973
- Terms expiring:
  - Herschel L. Browns
  - George C. Turner
  - William M. Lees (unexpired term of Francis W. Young)
  - Morgan M. Meyer
  - Glen E. Tomlinson (unexpired term of Joseph R. Mallory)
  - Boyd E. McCracken (unexpired term of Carl E. Clark)
- j. Election of alternates to fill any other unexpired terms resulting from prior elections
10. Unfinished business
11. New business
  - a. Fixing of the per capita assessment for 1972, based upon the recommendation of the Board of Trustees
  - b. Selection of the meeting place for 1974
  - c. Election of Emeritus, Retired members and those whose dues have been cancelled for cause
  - d. Other new business
12. Adjournment, *sine die*



# 1971 House of Delegates

## Committees

### COMMITTEE ON CREDENTIALS

Edward DuVivier, *Co-Chairman* (DS)

Charles P. McCartney, *Co-Chairman* (CMS)

Harold Lueth (CMS) Charles A. DeKovessey (DS)

Stanley E. Ruzich (CMS) Wm. Walton (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

Standby:

John P. Pope (DS)

Cyril Gallati (CMS)

Eugene Pitts (DS)

Eugene F. Diamond (CMS)

### REFERENCE COMMITTEE ON RULES & ORDER OF BUSINESS

Meyer Shulman, *Chairman* (DS)

Harold Kolb (DS) Clarence A. Norberg (CMS)

James A. Sandrolini (DS) Charles J. Weigel (CMS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close co-operation with the Speaker and the Vice-Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

The first meeting of the committee should be scheduled on Sunday morning, May 16, in order to have a report to present at the first session of the House on Sunday afternoon, as one of the first items on the agenda.

Standby:

Lee L. Johnson (DS)

W. O. Ackley (CMS)

Alan M. Taylor (DS)

### TELLERS & SERGEANTS AT ARMS

Vincent C. Sarley, *Chairman* (CMS)

James C. Parsons (DS) Loren B. Horton (CMS)

W. R. Malony (DS) E. J. Lukaszewski (CMS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot vote is scheduled, or the House goes into executive session.

Standby:

George W. Holmes (CMS)

C. E. Cawvey (DS)

Donald H. Dexter (DS)

Reference Committees will meet 7 p.m.,  
Sunday, May 16

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Room: Nashua

A. Everett Joslyn, *Chairman* (CMS)  
Lawrence L. Hirsch (CMS) C. P. Cunningham (DS)  
Howard C. Burkhead (CMS) Boyd McCracken (DS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution & Bylaws.

Staff: Mr. Smithers

Standby:

James W. Ford (CMS)  
Marcus Everett (DS)  
Wm. E. Adams (CMS)  
Carl Sandburg (DS)

## REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND ADMINISTRATION

Room: Rainbow

Joseph R. DeCaro, *Chairman* (CMS)  
Vincent Freda (CMS) George Alvary (DS)  
Frank J. Saletta (CMS) J. M. Ingalls (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

President

President Elect

1st Vice President

2nd Vice President

Secretary

Chairman of the Board

Trustees from the Eleven Trustee Districts

Trustee-at-large

Speaker of the House

Vice Speaker of the House

Chairman—AMA Delegation

Executive Administrator

Advisory Committee to the Auxiliary

President—Woman's Auxiliary to ISMS

BOARD COMMITTEES:

Policy Committee

Committee on Committees

Committee to Study Osteopathic Problems

Ethical Relations

Staff: Mr. Slawny

Standby:

Morris T. Friedell (CMS)  
Earl V. Klaren (DS)  
C. Malcolm Rice, Jr. (CMS)  
Clarence Walton (DS)

## REFERENCE COMMITTEE ON EDUCATION & COMMUNITY HEALTH SERVICES

Room: Sea Biscuit

Barry Seng, *Chairman* (DS)  
John J. Ring (DS) Allison L. Burdick, Sr. (CMS)  
Allan L. Goslin (DS) Coye C. Mason (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

COUNCIL ON EDUCATION & MANPOWER

Allied Health Education

Continuing Education

Advisory to SAMA

Scientific Assembly

Student Loan Fund

COUNCIL ON ENVIRONMENTAL & COMMUNITY HEALTH

Public Safety

Child Health

Maternal Welfare

Nutrition

COUNCIL ON MENTAL HEALTH & ADDICTION

Alcoholism

Narcotics

DIRECTOR: Department of Public Health

DIRECTOR: Department of Mental Health

Staff: Mr. Ott

Standby:

John F. Hubbard (DS)  
Wm. A. Hutchison (CMS)  
Cyril J. Anslinger (DS)

## REFERENCE COMMITTEE ON FINANCES BUDGETS & PUBLICATIONS

Room: Equipose

Morgan M. Meyer, *Chairman* (DS)  
Robert Stone (DS) Francis W. Young (CMS)  
G. W. Giebelhausen (DS) Herschel L. Browns (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Treasurer

Benevolence Committee

Educational & Scientific Foundation

*Illinois Medical Journal*

Publications Committee

Editorial Board

Editor

The Budgets prepared and approved by the Board and submitted for the information of the House

The Audit of Society accounts for the year 1970 as ordered by the Bylaws (By Peat, Marwick & Mitchell)

Staff: Mrs. Koelbel

Standby:

Merle Jacobs  
Paul Theobald (DS)



## REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

Room: Discovery

James P. FitzGibbons, *Chairman* (CMS)  
Roland A. Kowal (CMS) J. P. Campbell (DS)  
John S. Hyde (CMS) E. G. Ference (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

### COUNCIL ON LEGISLATION & PUBLIC AFFAIRS

Public Affairs Committee

Eye Committee

Ear, Nose & Throat Health Committee

### MEDICAL-LEGAL COUNCIL

Impartial Medical Testimony

Laboratory Services

Licensure

Professional Liability

TASKFORCE, Comprehensive Health Planning

Staff: Mr. Selleck

Standby:

Michael J. Kutza (CMS)

V. P. Siegel (DS)

Coleman J. O'Neill (CMS)

Ross Hutchison (DS)

## REFERENCE COMMITTEE ON ECONOMICS & SOCIAL SERVICES

Room: Swaps

Edward A. Razim, *Chairman* (CMS)  
David S. Fox (CMS) Robert Becker (DS)  
Anna A. Marcus (CMS) John Ovitz (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

### COUNCIL ON ECONOMICS & PEER REVIEW

Advisory to the Division of Vocational Rehabilitation

Drugs & Therapeutics (Advisory Com. to IDPA)

### BOARD COMMITTEE

Committee on Health Care Financing

DIRECTOR: Illinois Dept. of Public Aid

DIRECTOR: Illinois Div. of Vocational Rehabilitation

Staff: Mr. Lotharius

Standby:

Murry M. Paull (CMS)

Dale Learned (DS)

Eugene T. Hoban (CMS)

L. B. Hussey (DS)

## REFERENCE COMMITTEE ON PUBLIC RELATIONS & MISCELLANEOUS BUSINESS

Room: Candy Spots

Jack Means, *Chairman* (DS)  
James A. McDonald (DS) Samuel L. Andelman (CMS)  
Warren D. Tuttle (DS) David T. Petty (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees and upon any other matters referred by the Speaker.

### COUNCIL ON PUBLIC RELATIONS & MEMBERSHIP SERVICES

Physician Placement Service

Medicine & Religion

Insurance

### COUNCIL ON SOCIAL & MEDICAL SERVICES

Aging

Rehabilitation Services

Nursing

TASK FORCE: Physician Shortage &

Services to Medically Deprived Areas

Staff: Mr. Westerbeck

Standby:

S. P. Plassman (DS)

Rudolph W. Ziegler (DS)

Arne E. Schairer (CMS)

## SPECIAL REFERENCE COMMITTEE (for House of Delegates)

Saturday, May 15

10:00 a.m.

Room: Parlors 4 & 5

Robert Heerens, *Chairman* (DS)  
J. P. Schweitzer (CMS) Clifton L. Reeder (CMS)  
Maurice D. Murfin (DS) Leon L. Ampel (CMS)

This committee shall consider and submit its recommendations on any matters referred by the Speaker which may be of an emergency nature.

Edward Krol (CMS)

Erwin M. Patlak (CMS)

H. V. Fine (DS)

F. C. Kuharich (DS)

## Calls Will Reach You Easily at the '71 Convention

Doctor, please inform your staff that while you are attending the ISMS Convention, you may be reached through the Physician's Message Center from 9 a.m. to 5 p.m. Monday, Tuesday and Wednesday. The number is:

312-255-3277

This is a direct connection which will not go through the hotel switchboard.

# officers and administration

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## PRESIDENT

A day by day report on my presidential activities during the past year would provide an endless saga in which few would be interested. Instead, I will arrange my activities in different areas and emphasize factors that I believe are significant.

### ISMS activities

I attended all the committee and council meetings that I could, which included most of them. The information gained has kept me abreast of the problems and activities of our society. All Board of Trustees meetings have been attended as well as all meetings, except for one, of the Executive Committee.

The District meetings on the 1970-71 President's Tour included: Peru, Oct. 8, (2nd District); Jacksonville, Oct. 22, (6th District); Waukegan, Nov. 11, (1st District); Effingham, Nov. 19, (7th District); Bloomington, Jan. 12, (8th District); Carbondale, Feb. 3, (9th and 10th Districts); Joliet, March 10, (11th District); and Rock Island, March 24, (4th District). Although some of these meetings were not well attended, I believe them to be significant, for it permitted the President and staff to gain first-hand information on conditions throughout the state, and conversely it gave local physicians an opportunity to report their problems and complaints. Public contact through radio, television or press conferences was usual on all President Tour stops. In addition, I spoke at the meetings of the North Shore and the Douglas Park Branches of the Chicago Medical Society.

A four-part newspaper series was prepared with the assistance of the Division of Public Relations, and published in numerous dailies during Community Health Week, Oct. 18-24. The articles were entitled "Group Practice," "Infant/Maternal Mortality," "Malnutrition" and "The Ambulance Crisis." I presented the luncheon address at our most successful Leadership Conference, Nov. 21, discussing methods to assist in providing medical care to all of our people.

### AMA activities

The AMA meeting in Chicago last June provided many pleasant responsibilities for me as President of the host State Society. The induction of our own Dr. Walter Bornemeier as AMA President also made the meeting more enjoyable.

The AMA Clinical Conference was held in Boston late in the fall. I attended the House of Delegates sessions and several Reference Committee meetings. At an AMA luncheon for State Presidents, I heard Senator Herman Talmage, the second ranking senator on the Senate Finance Committee, spell out details of the Bennett Amendment to the Social Security Act. This, as you know, de-

fined the Professional Standards Review Organization.

### Other society meetings

I attended the Indiana State Medical Society meeting in October and plan to attend those of Ohio, Wisconsin, Missouri and Iowa. In August, I attended the Fourth World Conference on General Practice at the Palmer House, in Chicago. I also attended the annual meeting of the Illinois Welfare Association.

On Oct. 10, I addressed the Illinois Broadcasters Association at their Annual Convention in Springfield. This talk, based upon research by our Division of Public Relations, disclosed that widely publicized I.R.S. accusations against 3,000 physicians for cheating in Medicare were erroneous, and in most instances were based upon errors in programming of the intermediary or government computers. Wide publicity followed our disclosure and the AMA continued the investigation, demanding retraction.

### Blue Shield and the State of Illinois

I represented our Society at all Blue Shield Board meetings and several meetings called by various departments of our State Government. These included meetings with representatives of the Bureau of the Budget, Comprehensive Health Planning, Public Aid, Public Health and Mental Health Departments.

On Feb. 2, I attended the President's Prayer Breakfast in Washington D.C., and the Physician's Seminar held immediately afterward. I planned a return to Washington, April 25, to attend the ISMS Public Affairs Round-Up.

### Summation

In my Inaugural Address I listed four areas in which I planned to place special emphasis: Peer Review, Malpractice, Continuing Education, and changes in medical care distribution with special emphasis on Group Practice. At this time, nearly all county medical societies have Peer Review Committees. Symposia on Malpractice have been presented at all the District President Tour meetings.

Concerning Continuing Education, I have been quite active in urging the self-testing unit of the University of Illinois to be a part of our service to physicians at our Annual Meeting, and in instigating the 36 refresher courses, which are to be presented at the Annual Meeting. Also great effort has been expended in finalizing an "independent Council of Continuing Education," a move started by our former President, Dr. Edward W. Cannady. It is our hope to set up such a council, bringing together into one organization all those that are interested in producing or sponsoring continuing education for Illinois physicians. I wish to report too, that many new group practice units have been formed throughout the State. In the past year, 281 new Illinois medical corporations have been incorporated. On Febru-



ary 15, of this year, Illinois had a total of 981 medical corporations. Many other groups are organized as partnerships, and since it is probable groups of all kinds average about five members each, it is obvious that about half of the doctors in the state are already working in a group practice setting.

In closing, I wish to express my profound gratitude to not only our division heads, but all of our staff who have been so helpful and so patient with me. I wish specifically to thank Mr. Roger White for all his assistance and his forbearance.

J. Ernest Breed

## PRESIDENT-ELECT

Your President-Elect has endeavored, during this past year, to avail himself of all possible opportunities to enhance his knowledge of the policies, positions and potentials of the Illinois State Medical Society.

These endeavors have included attendance at meetings of all Councils and Committees to which I have been assigned, as well as many not assigned, which I attend as a guest for informational purposes. I made most of the stops on the President's Tour, attended both AMA meetings, appeared as a guest at three significant meetings in neighboring states, and attended the Annual State Meetings of the Illinois Hospital Association and the Illinois Pharmaceutical Association. A mere recital of dates, places, and subject matter of these activities would add nothing to this report and have been elsewhere reported.

Perhaps more important than some of these formal meetings were the opportunities to converse extensively with many members throughout the state and to develop information on particular problems in a variety of areas and a variety of population concentrations. I invited many members (and still do) to write me with regard to their local problems, hopes and expectations from their Society and their officers. Many members have done this and so apprised me of general and particular subjects which one may seldom or never hear in formalized assemblies.

Your President-Elect has eagerly accepted invitations to appear before many non-medical groups to present "the other side" of the medical problem which is denied them through the news media. I have done this with a discourse entitled "Medicine's Posture in the 70's" followed by a question and answer period. It has been both gratifying and surprising to discover the intense interest people have in learning more about what doctors think, feel, and believe about today's medical care quality, its costs, its limitations and its potential.

In view of the above, it would seem timely to reconsider some of our state society activities. There has been extensive discussion among the officers, trustees and staff regarding the rather unpredictable attendance and participation in various conferences, district meetings and some segments of the President's Tour. Medicine at the organizational level may be misdirecting its energies by concentrating too much on carrying messages to other doctors who may be too active, too dedicated, too tired or too busy to listen. We are a tiny minority. Our interests, and those of the people we serve, may best be served by appealing to—and enlisting the interest of—the great majority of our fellow citizens who may be most affected by ill-advised changes in any or many of the facets of local, state and national health care.

L. T. Fruin

## FIRST VICE-PRESIDENT

As an officer of the Illinois State Medical Society during the past two years, I have observed with interest the proceedings of the Board of Trustees. Until the meeting of

the Board in January, 1971, I was almost convinced that organized medicine had lost its capacity to "view with alarm." While we may be justified in resenting the limitations of the length of stay of hospitalized public aid recipients as suggested by the IDPA, we cannot escape the fact that over-utilization does occur and that such abuses must be corrected by physicians through effective methods of Peer Review, and setting up guidelines for adequate, efficient treatment of these patients. This is a responsibility we cannot abdicate.

Now that we are in the decade of the seventies, we are faced with the need to make generally available adequate health care as a part of the ultimate fulfillment of an authentic human existence for every American citizen. The gap between the rhetoric and reality is widened by the manpower shortage in medical and para-medical fields. An attempt to meet this problem by training and certifying Physician Assistants apparently has the endorsement of the Illinois State Medical Society.

February 24, 1971, I traveled to Springfield to testify before the Senate Welfare Committee on behalf of S.B. 24, Coulson's Physician Assistant bill. However, I must report that I have certain misgivings concerning this bill. It is my candid opinion that by endorsing this bill we will be creating a Frankenstein. We are already confronted with the problem of continued competence of physicians. Why compound our problems by adding the physician assistant, many of whom will be overly-officious and will require cautious watching? If abortion is legalized in the state of Illinois, you may be certain that many illegal abortions will be performed by the physician assistants. Then too, there is another aspect of this problem which must be considered. American medicine is presently a system for the delivery of health care which is geared basically to a middle class society. The creation of the physician assistant is an attempt to supply health care of sorts to residents of rural areas and the inner city. These people are American citizens too and should resent and oppose any attempt to supply them with anything less than *first class* medical care by well trained physicians. Perhaps, I should not question the wisdom of an organization which lobbies against legislation to make illegal the unethical practice of feesplitting, yet will support such a bill as S.B. 24. Support of this legislation will damage our image and further contribute to the declining prestige and power of organized medicine.

Organized medicine and medical schools must accept responsibility for the present shortage in medical manpower. The Malthusian doctrine has been known for well over a hundred years, yet American medicine failed to recognize the need to produce more physicians to cope with the population explosion. It may be true that organized medicine is "crisis oriented," but at this point in our dilemma we must pause to reflect upon what is best in the long run for the American citizen. A crash program to produce more physicians is in order, such as was carried out during World War II and the accelerated programs presently under consideration. We should support and encourage these efforts. To entice physicians to practice in the inner city and rural communities meaningful tax incentives may be proposed as well as the provision of facilities for group practice and hospital care. This must be accompanied in the inner city by a change in the philosophy of education for minorities commonly shared by School Boards through this country.

During the decade from 1960 through 1969, it has been estimated that the amount of money spent on health care has doubled in the United States. Where does the money go? It has been shown that the money is going chiefly to modern hospitals and university based medical centers. Here, in these institutions, most of the medical research is conducted, new medical technology is used and



developed, and most of the community health care programs are sponsored. Most of the money paid for health care comes from third-party carriers, especially Blue Cross and Blue Shield, and from Medicare and Medicaid. It is interesting that the hospitals that receive this money, for the most part, control the organizations that give the money . . . through a "system of interlocking directorates." "The Blues" do not oppose the rise in hospital costs, and hospitals support higher medical insurance rates. By freezing the doctors' fees, these institutions and insurance plans force the physicians to help subsidize the ever rising costs of medical care which are presently skyrocketing beyond the reach of the middle class. These rising costs can no longer be blamed on the greed of individual doctors, but rather on the greed of hospitals and university based medical centers, largely because of increasing institutional profits, higher individual salaries, and the "grant-eaters" of medical research. This institutional monopoly is the "medical establishment."

The destiny of the American physician is in the hands of this monopoly and will be more so, if the prestige and power of organized medicine continues to decline. It would appear that organized medicine must redefine its goals based on a five or ten year plan to assure adequate medical care for the benefit of every American citizen. Our staid, conservative, myopic leadership must be replaced by more aggressive, more imaginative, liberal, socially conscious men who are in tune with tomorrow, if we are to participate in the determination of our destiny.

George Shropshire

## SECOND VICE PRESIDENT

The excitement and thrill of responsibility for sick patients experienced as an intern is born again.

Today the practicing physician, singly and collectively, and the private practitioner in particular, is sick. Your Board of Trustees experiences the excitement and thrill of directing the diagnostic and therapeutic efforts on behalf of the membership of ISMS individually and on behalf of the House of Delegates collectively.

Diagnostic efforts include membership polls, President's Tours and in-depth studies by individuals, sub-committees, committees, councils, officers, liaison personnel and ISMS staff, of the problems facing medicine today.

As politicians sense the voting appeal of promises of "free" medical and hospital care for all, medicine becomes politicized and consequently greater attention must be paid by doctors to political and legislative problems. This is indeed tragic and unfortunate but like war, is necessary for self-preservation. As government closes in on the private practice of medicine, physicians must, of necessity, devote more time and treasure to self-preservation. The alternative is slavery to a bureaucratic monster with loss of control of the practice of medicine and subsequent deterioration of doctor-patient relationship, and ultimately, destruction of the lofty standards of medical care so painstakingly constructed over the past fifty years.

Therapeutic efforts involve research and development of Foundations for Medical Care, moral support of AMPAC and IMPAC, testimony in Springfield—supporting policy of the ISMS House of Delegates, promotion of unity of the medical professionals in Illinois regardless of race, creed, country of origin, political affiliation, sex, place of residence, condition of employment or type of practice, providing a sounding board for all viewpoints by encouraging all members of ISMS to attend reference committee meetings of this House of Delegates and to attend district meetings on the President's tour.

Physicians, by nature and training, are rugged indi-

vidualists, not well suited to regimentation. Consequently, resentment against governmental compulsion runs deep.

ISMS must channel this anger into hammering out a practical *modus vivendi* so that patients, physicians, hospitals, insurance carriers, and governmental agencies can live together in harmony for mutual benefit.

We shall negotiate with third parties involved in patient care from a position of strength, speak softly, and carry a big stick.

C. J. Jannings, III

## SECRETARY-TREASURER

The report of the Secretary-Treasurer will be found under Finances and Budgets, page 398.

## TRUSTEES

### First District

Scheduled visits to each of the ten counties of the District have served to bring attention to the local problems. Chief among these has been the difficulty in recruiting physicians for the more rural areas. Delays and frustrations have occurred as a result of licensure (reciprocity, endorsement, etc.) and the competition for the limited number of physicians available.

Informing the membership of the counties about the growing thrust toward prepaid medical concepts has been the chief concern of your trustee during the year. It was gratifying and significant that the First District was well represented at the Leadership Conference which dealt so well with the subject of "Health Care Delivery."

The district meeting of delegates and alternates held at Rockford, in early fall, was very well attended and highly productive in the exchange of information and achieving direction in many important matters.

Joseph L. Bordenave

### Second District

The Second District was pleased once again to be visited by the President of the ISMS. The District has been fairly active, with two counties recently initiating county Peer Review Committees. However, in our area the shortage of doctors still looms as the number one concern. We hope new medical schools will relieve this.

We are also most concerned by the attacks leveled against us as a profession by many varied groups. In our area there is some talk of forming a "guild" to help answer these attacks. We hope ISMS and the AMA can offer enlightened guidance during these times of change.

W. A. McNichols, Jr.

### Third District

Late report received; see page 417.

### Fourth District

This initial year as trustee of the Fourth District has been devoted primarily to indoctrination and learning the requirements of this position.

As a consultant to various committees, I have tried to attend as many of the committee meetings as possible and have kept abreast of their proceedings.

In an attempt to better understand the needs and wishes of the county societies within the Fourth District, a Trustee's Advisory Committee was established. This was composed of the presidents, secretaries, delegates and executive directors of the county societies. The first meeting of this Advisory Committee was held in Galesburg on February 17.



The Fourth District Trustee's Advisory Committee allowed an excellent forum for exchange of opinions and for the projection of county society needs. It is hoped that this free and open exchange of ideas will continue so that this Trustee may act in the best interest of the county societies and the membership of these societies. It will be our hope in the next year to have two or possibly three meetings of the Trustee's Advisory Committee to further this effort.

Fred Z. White

### Fifth District

During this first year of my trusteeship I felt that I was being initiated into the Board activities. As such I have formed some idea as to what can be accomplished in the future. My activities largely encompassed those of meeting attendance. I have met with several of the counties in the District for an exchange of ideas. The most useful meeting was that held on February 4, in Lincoln, which was well attended by officers, delegates and interested members of the counties of the Fifth District. Fortunately, Mr. Roger White was present to answer questions directly. These questions particularly concerned the possible formation of a Foundation for Medical Care by the State Society. Many members of the Society, no matter what their position, do not completely understand the implications of a Foundation. A clear and detailed document has been sent to every member of the Society. Physicians should study this concept before the Annual Meeting. If this is not done, I am afraid that after a lengthy discussion no point will be reached when the House of Delegates meets.

I have been appointed to only one active committee of the Board of Trustees—the Publications Committee. This has met three times. Activities of this committee are ably directed by Dr. Reisch. I am attempting to learn a portion of what he knows, but this will take time.

I have attended, as consultant, designated committees. Unfortunately, an ambitious program was to be held in Springfield by the Committee on Aging but this was called off because of presumed lack of interest. Insofar as this was an excellent program, I am sorry it was not given. Had I been consulted I would have advised against this particular action, since I'm sure there would have been many "walk-ins." Many of our physicians in McLean County expressed a desire to attend, but did not send a card since they were not going to stay for a meal.

The Insurance Committee activity is well documented and is ably chaired by Dr. Clifton L. Reeder. Again I am really learning more than giving while attending.

The Drug Committee, chaired by Dr. Robert C. Muehrcke, is very active. It is my opinion however, that the "Drug Manual for Physicians" needs some revision and particularly direction in its selection of drugs to be included. The recommendation has been passed by the Board of Trustees, at my request, that all drugs submitted by reputable pharmaceutical concerns and have proven efficacy as documented by the "Medical Letters" or publications in major medical journals be included. Furthermore, generic prescribing can be encouraged by using generic names when possible, particularly with single drugs, but including after the generic names, all of the trade names of the drugs produced by reputable pharmaceutical houses. The doctor prescribing generic drugs would then be assured that the prescription would be compounded from those in the parenthesis alongside the generic name. This would permit the druggist to select the less expensive drug listed. In addition, it might be well, if possible, to indicate the drug with an asterisk which is the "best buy" as to expense and efficacy. To

do this would require additional work on the part of the committee, but I feel it would be worth while and might result in savings to the Department of Public Aid. I have not been able to attend meetings of the Council on Mental Health as a consultant. This activity is on Saturday afternoon, which I feel is not a feasible time for me to be away from my community.

I should like to thank Dr. Breed for his attendance at the McLean County Medical Society meeting on January 12. This was in place of the "President's Tour." Guests and members of the Society truly appreciated his informative talk.

A. Edward Livingston

### Sixth District

A district meeting of the Sixth District will be held on Sunday, May 16, 1971, at the Arlington Park Towers Hotel in Chicago immediately preceding the Annual Meeting of the Illinois State Medical Society; all Delegates from the Sixth District are urged to attend.

No problems have arisen requiring attention of any of the District Committees. Peel Review Committees have been appointed in most counties.

The shortage of practicing doctors within the district steadily increases and the rural areas especially are poorly supplied with physicians. As the various governmental and ivory tower planners produce one more costly scheme after another "to improve health care delivery" the crucial factor in any improvement remains largely ignored—the absolute necessity of many more well trained physicians who *want to treat sick people!* All the planning and research are with little meaning if the vehicle to deliver the benefits of planning and research does not exist. "An innovative approach and a re-ordering of priorities" which seems to have merit is the application of more common sense to a few of the health and welfare problems in this country.

I have attended all meetings of the Board of Trustees during the past year and most meetings of the Committees on which I serve. The dedication of various members of the ISMS to the welfare of our society is inspiring. I wish to express my appreciation to all staff members in both the Chicago and Springfield offices for their assistance to me in the past year.

Mather Pfeiffenberger

### Seventh District

The Committees on Ethical Relations, Grievance and Prepayment Plans have not been called upon for any problems during the past year.

Physician shortage with constant attrition continues to plague the Seventh District. The Recruitment Committee of the Macon County Medical Society has been working diligently with no results. Christian County is more fortunate with three MDs recruited.

The Emergency Room Service by group employed local physicians has alleviated the physician work load in Decatur, much to the satisfaction of Macon County Medical Society.

The continued Medical Education Program, which was reported one year ago, being held alternately at St. Mary's Hospital and Decatur Memorial Hospital by their respective staffs, continues to meet with great success. It is called the "First Friday of the Month Meeting on Medical Education." Attendance is still excellent and the courses are given formal credit by the Academy of General Practice. At Decatur Memorial Hospital, a Neurological Symposium was given by a panel of three from the Mayo Foundation. A \$25 tuition fee was charged and the attendance was remarkable, with over 100 pres-



ent. Formal credit was also given for this.

The MECO Project brought into the District, particularly Decatur, eight medical students; seven were freshman and one was a sophomore. They were divided at weekly intervals to the Practice of Internal Medicine, Obstetrics and Gynecology, Surgery, Radiology and General Practice Departments. These young men were exceedingly bright and articulate, and voiced tremendous appreciation for the time given and the good ground work through observation and contact with medical practice in areas such as the Seventh District.

The Illinois Supreme Court decision classifying blood as a product and not a service, reversing a decision of the lower court in the case of *Cunningham vs. MacNeal Memorial Hospital*, has created a great deal of apprehension, because of its potential for liability. The elimination of the two year statute of limitation and liability action, as well as modification of the discovery rule allowing action to commence within two years after date of discovery of the incident, has caused considerable dismay. It is hoped that these will be corrected through legislation. Contact your legislators.

To summarize, successful recruitment of physicians has been minimal, continued medical education gratifying, hospital emergency service most helpful and the MECO project a distinct success.

Your Trustee expresses appreciation to the component societies and their active auxiliaries for their cooperation and support.

Arthur F. Goodyear

### **Eighth District**

There have been no requirements for District Committees to meet. I have attended all meetings of the Board, Committees to which assigned, and have tried to meet with many officers and delegates of the district.

Being my first year, I have tried to become fully oriented and have attempted to fulfill my obligations and do a good job.

Eugene P. Johnson

### **Ninth District**

I have attended all the Board of Trustee meetings and committee meetings during the last year.

On August 13, I attended a meeting at which Dr. Albert Snode, State of Illinois Coordinator of Health Services, was obtaining information about a proposed 500 bed Regional Hospital in Mt. Vernon. Up to the date of this report no formal application to any Health Services Coordination Program has been made, but an informational meeting has been held.

On September 1, and December 21, I attended meetings of the Advisory Council to the Bi-State Regional Medical Program. One program is to evaluate post-graduate medical education by studying records of 500 patients in hospitals in Farmington, Missouri, and Litchfield and Mt. Vernon, Illinois.

Several MECO students spent the summer at various hospitals in the District.

The last week of September, I represented the ISMS at a testimonial dinner for Dr. Virgil Decker, Metropolis, in Massac County.

On October 14, I presented Dr. Chester H. Williams, of Franklin County, his ISMS 50-year plaque and pin.

In early November, the Ninth and Tenth Trustee Districts held their district meetings in Belleville in conjunction with the annual meeting of the Southern Illinois Medical Association.

On January 27, I attended a meeting of the Wayne County Medical Society at which Dr. Richard Moy,

Dean of the Southern Illinois Medical School, outlined the program of the new school.

The Williamson County Medical Society meeting was attended February 2, and on February 3, I attended the President's Tour held in Carbondale.

Topics most frequently heard at county meetings are:

1. Shortage of MDs
2. Malpractice insurance
3. Fee schedules and fees paid by third parties
4. Foundations for Medical Care
5. "What is the State Medical Society doing for us?"

More recently, two other topics are being discussed:

1. What about the TB Hospital in Mt. Vernon?
2. Who is backing the proposed 500 bed Regional Hospital in Mt. Vernon?

The District Ethical Relations or District Peer Review Committees have had no problems referred to them before February 5.

The societies in the Ninth District have shown more interest in Society affairs during the past year than in previous years and are to be complimented for this.

The staff of the ISMS office has rendered much assistance to me during the past year and I thank them.

Charles K. Wells

### **Tenth District**

Categories of activities and meetings attended:

1. All county societies in District visited
2. AMA—Clinical and Annual
3. Regional Medical Program (Bi-State)
4. Comprehensive Health Program (Bi-State)
5. Belleville Area College—Department of Nursing
6. Leadership Conference—Chicago
7. Nurse Scholarship Association of St. Clair County
8. AMA Committee on Health Care for the Poor
9. All meetings of ISMS Board of Trustees
10. Combined Ninth and Tenth Districts President's Tour, Carbondale.

Developments:

1. Several hospitals in building expansion programs.
2. Despite expansion of existing and new construction, nursing homes and other facilities, a shortage of beds still exists.
3. In spite of the fact that several counties have acquired additional new physicians, there is still a shortage, especially in the Southern area.
4. Several new black physicians have located in East St. Louis.
5. Both Bi-State RMP and CHP (ARCH) are accelerating their planning and services to the profession and citizens of Illinois.
6. An auxiliary to the Jackson County Medical Society has been established and is active.
7. The physicians of Union County, under the leadership of Dr. Rader and others, have reactivated through the help of Mr. Philip Thomsen, Jr., of ISMS Staff.
8. Growth of membership in St. Clair County Medical Society entitles them to additional delegate to ISMS.

A poll of greatest concern to member-physicians, reveals:

1. Medical liability (malpractice problems)
2. Physician shortage and distribution
3. The prospect of government or hospital control over their service in delivery of medical care
4. Distress over unfair representation to the public by news media
5. Dissatisfaction with third party fiscal agents in-



cluding reduced and delayed payments.

6. The role of S.I.U. Medical School

7. Peer review

Physicians and their wives throughout the District have provided leadership and participation in health careers, nurse education, hospital expansion, home health care, community health programs, AMA and ERF, political education and constructive legislation.

Acknowledgment to:

1. Dr. E. W. Cannady for his past services as President of ISMS, and posts formerly held with RMP and CHP.

2. Dr. V. P. Siegel (now resigned) for his yeoman service in legislative matters both on the state and national boards while a member on the respective legislation councils.

3. Physicians and their wives for warm hospitality on my visits, and for their many achievements as individuals and members of our organization.

4. ISMS staff for the cooperation, expertise and help in the conduct of the affairs of our district.

Willard C. Scrivner

### **Eleventh District**

As the Trustee of the Eleventh District it was my privilege to serve as Chairman of the new Committee on Health Care Financing. I would recommend the reading of the report of this Committee to you.

I also served as a member of an Ad Hoc Committee to discuss the proposed Illinois Health Facilities and Service Planning Act. This is a most important and vital subject to the practicing physician and warrants your close perusal.

A district meeting of the Delegates of the Eleventh District was called and it is my personal feeling that these should be ongoing events at regular periods throughout the year.

The majority of time and your Trustee's efforts to Dateline has been directed to the study and endorsement of the new concept of FMCs.

The tremendously involved subjects of each Board of Trustees meeting should be carefully perused by each member of the society as outlined on the minutes of each meeting.

Joseph R. O'Donnell, Jr.

### **TRUSTEE-AT-LARGE**

It has been a pleasure and a privilege to serve the Illinois State Medical Society for many years in numerous positions. An illness in the late summer forced me to curtail my schedule and be not as active as I had expected. However, I was able to attend most of the Executive Committee and Board of Trustees meetings and participate in numerous conferences on both the state and national levels.

During my inaugural remarks as President of ISMS two years ago, I emphasized three major goals: (1) Physicians should attempt to hold the line on the cost of delivery of medical care as much as possible; (2) Establish an independent Council on Continuing Medical Education; and (3) Establish internships and residencies in community hospitals in an attempt to encourage more physicians to practice other than in the larger cities.

I believe most physicians are attempting to keep their fees as reasonable as possible. However, continued inflation, constant threats of malpractice suits resulting in increased insurance rates, and increasing demands for numerous reports requiring more clerical staff have caused a considerable increase in the cost of operating a medical practice. As a result, many physicians have been forced to increase their fees to cover their increased cost of

operation. Unfortunately, there are other factors, such as rapidly increasing hospital costs, which have a much greater effect on the cost of medical care.

Progress is being made toward the establishment of an independent Council on Continuing Medical Education and a report should be available for the House of Delegates in May.

The establishment of more internships and residencies in community hospitals must be a long term goal since this will depend upon an increased number of medical graduates. There are many more internships and residencies available than there are graduates to fill them.

We are aware of the increasing inroads of government and other third parties in the practice of medicine. Every physician must become increasingly alert and active to keep control of his own profession. Unfortunately, too many physicians do not seem to be unduly concerned with the threats facing the loss of their freedom in the delivery of medical care.

As I retire from the Board of Trustees, I want to thank the officers, Board members, our executive administrator, department directors and staff for their cooperation during the years that I served on committees, as Speaker of the ISMS House of Delegates, as President of ISMS, and a member of the Illinois delegation to the AMA House of Delegates.

Mrs. Frances Zimmer has been very loyal and dedicated throughout her years of service to ISMS, and will be missed by all of us following her retirement. Our best wishes go with her for health and happiness.

Edward W. Cannady

### **CHAIRMAN OF THE BOARD OF TRUSTEES**

Your chairman, in attempting to fulfill the requirements and responsibilities expressed and expected of the office, has endeavored to promote unity, strength and efficiency in conducting the affairs of the Board of Trustees.

1. All appointments to committees or councils and ad hoc task forces were made upon trustees' recommendations.
2. Special appointments and envoys to represent ISMS at various meetings and affairs were chosen because of their ability and availability to do the best job for ISMS.
3. The Board has implemented policy and instructions received from the House of Delegates while exercising alertness for new trends and developments having a bearing on freedom and responsibilities of ISMS members.

### **Developments**

1. ISMS furnished leadership and cooperation in promoting the State administration's bond issue for control of pollution.
2. Approved and authorized changes in ISMS staff proposed by Executive Administrator, Mr. White, including elevation of Mr. James Slawny to Assistant Executive Administrator and establishing field service to county societies in person of Mr. Philip Thomsen, II.
3. Negotiated a satisfactory rental contract for much needed additional space for our Chicago office.
4. In recognition of the importance of the Woman's Auxiliary, we have established, for their use, a three-day per week secretary service located in Monmouth, Illinois.
5. The Executive Committee of ISMS and IHA have met to exchange views on points of mutual interest and concern with appointment of sub-committees to research and develop satisfactory approaches to licensing, medical liability, physician assistant



and other matters.

6. Closer liaison with county societies has been fostered by conferences between Mr. Roger White and county society executives.
7. Assisted by medical liability education portion of President's tour, the Medical Legal Council is accelerating efforts for constructive development with members of the Illinois Bar Association.
8. Sincere cooperation has prevailed in all areas of activity with SAMA, including prescribed representation, mailings and MECO projects.
9. Procured special legal counsel for feasibility study on the establishing of a physician guild. The matter is currently being researched.
10. The October Board meeting was held in Belleville, in accordance with the idea of convening one meeting per year outside of Chicago.
11. Secured consultants of recognized stature for feasibility study on establishment of Foundation for Medical Care and P.R.S.O. services. Their findings will be reviewed and evaluated by officers, staff and county executives to develop a factual presentation to the House of Delegates for their information and action.

#### **Aims and Objectives of the Board**

1. Upon receipt of results from feasibility study on FMC, consult with staff, officers and county executives and others to develop proper presentation of material to the House of Delegates for their information and actions.
2. Press for constructive favorable development in mutual areas of medical liability with appropriate representatives of the Illinois Bar Association.
3. Foster and actively support legislation to correct dilemma on blood transfusions and hepatitis.
4. Maintain, through channels, concerted pressure on medical schools to fulfill their responsibility in providing increased enrollment for students, continuing education programs for practicing physicians, and Departments of General Practice.
5. Embrace austerity program of fiscal consciousness—
  - a. by eliminating certain expenditures associated with Board meetings by tradition, but not absolutely necessary;
  - b. by utilizing expanded new quarters for committee meetings; exacting a saving in both meal costs and hotel meeting room charges.
  - c. an envisioned saving accruing from a combined ISMS and CMS meeting in 1972.
6. In recognition of ISMS original commitment of \$18,000 to HCC, the progress made and their new source of funds, believe we should seriously consider a grant of \$3,000 for the next year in order to assure implementation of service and programs most relevant to the immediate needs of ISMS membership and thereby prevent a dues increase.
7. Respectfully recommend to the House of Delegates that the dues for 1971-72 remain unchanged.
8. Support the AMA stand on medical assistants.
9. Enhance the close relationship with officers and strategy committee members of the AMA delegation to develop both short and long range plans to insure Illinois physicians adequate representation at various levels of AMA.
10. Depending upon the occasion and matter under consideration, utilize boldness, tact, and diplomacy in conveying to all government agencies, third party carriers and others, a clear understanding of what the practicing physicians of Illinois stand for and what they will not stand for.

Willard C. Scrivner

## **SPEAKER OF THE HOUSE**

The Speaker's report is of necessity "foresight born out of retrospection." What is our function in 1971, considering our progress from the annual meeting in 1970?

The challenge to us as the policy-making body of ISMS is to examine the relevancy of our past and present positions and respond appropriately to the demand for contemporary pertinence. Significant statements are required in many areas from the House of Delegates. This year will be a big one!

Arlington Park Towers is a thrilling location. The newness will create problems of adjustment and logistics for staff and delegates. Patience and consideration will be required. The pressure of a full agenda for the House will compel economy of our time. To that end may I suggest preparation for the meeting? Read the April issue of the *IMJ*. Register early and review additions to the *Handbook*. Attend your district meetings. Be on time for the first session (it will begin on time). Testify at the Reference Committee hearings, make reservations with the chairmen if you need to be in several places and make your thoughts known. On the floor of the House help expedite the business.

The high calling of the physician to serve human needs is ever present. What we say and do in this forthcoming meeting, in many ways, will determine how we respond to and what our professional contribution will be for the future. I look forward to helping in the important forthcoming deliberations.

Paul W. Sunderland

## **VICE-SPEAKER OF THE HOUSE**

Report not received in time for publication.

## **EXECUTIVE ADMINISTRATOR**

The 1970 House of Delegates received and considered 55 resolutions, 13 of which were not adopted. Of the 42 resolutions accepted, 27 were adopted as presented or amended, seven adopted in substitute form, seven referred for study and one adopted in principle. The adopted resolutions have all received appropriate attention of the council or committee during the year and the respective reports of these councils and committees will show the final disposition or present status of implementation. Various additional actions taken by the House, in conjunction with council and committee reports, likewise have received attention and the reports to the 1971 House of Delegates will show the action taken to date.

## **Council and Committee Efficiency**

During the past year, a special effort has been made to improve the efficiency of council and committee work. Improvement has been made in the advance scheduling of council meetings to permit all of the committees to meet and render their reports to their councils in time for appropriate reporting to the Board of Trustees. This has been the procedure but in the past, the scheduling has not always achieved this desired objective. With few exceptions, we have tried to have one or more councils and the committees within that council, staffed by a single staff division. This allows for better coordination and continuity of action. This procedure is not new but we have given special attention to elimination of duplication of activity by the committees.

## **Staff Reorganization**

In January, staff assignments were reorganized to accommodate the retirement of Mrs. Frances Zimmer at the end of March and to provide for further efficiencies. Mr. James Slawny, former director of the Division of Public Relations, was named Assistant Executive Admin-



istrator with major responsibility for coordinating the work of all of the ongoing program activities. Division directors meet weekly under the guidance of Mr. Slawny to review the status of all projects and to plan their activities for the week ahead. The Executive Administrator conducts a routine monthly meeting of Division directors to consider general administrative policy and to further coordinate the administrative activity. A chart of the present staff organization is shown facing this report. The staff consists of 32 full-time employees, five part-time or contract employees, plus the *Journal* editor and legal counsel, both of whom serve part-time on retainer. The staff reorganization, initiated in January, involves a net increase of one full-time employee. This is the first increase in the staff complement since 1964.

#### **Additional Office Space**

There has been a long standing need for additional space in the headquarters office. As previously indicated, this is not due to an increase in the staff complement. The lack of adequate working space contributed to certain staff inefficiencies which badly needed correction. Particularly important was the need for more adequate meeting room facilities. Due to the small size of the previously existing single conference room, most meetings had to be held in hotels. This has resulted in at least a \$25.00 rental fee on the meeting room plus the cost of food service at banquet rates.

In March, additional office space was leased opposite the headquarters offices on the twentieth floor of the Stone Container Building at 360 North Michigan Avenue. The new space provides four additional offices, plus sufficient space for three to four secretaries, a conference room, and kitchen facilities to allow for the use of a catering service when meals are involved. This will result in substantial savings for meeting expense.

#### **Finances**

The financial position of the Society is set forth in the report of the Secretary-Treasurer and the official audit report. A modest surplus was achieved for the year 1970 after allowances for equipping and paying the rent on the new office space. To assist the Finance Committee and the Board of Trustees in exercising tight control over expenditures, the staff plays a vital role. Each Staff Director is responsible for monitoring the day to day expenditures in his Divisional budget. Any deviations from the budget must be accounted for, large expenditures must be approved in advance and competitive bidding exercised. Modern accounting and cost control procedures are used.

#### **Appreciation**

Your Executive Administrator wishes to pay tribute to the officers, members of the Board of Trustees, members of councils and committees and others, who have served in a most dedicated fashion throughout the year. Your President and the Chairman of the Board are called upon by the staff almost daily to make decisions on issues which arise. They, as well as the other officers and many Board members have responded to the Society's needs in magnificent fashion, often with great sacrifice to themselves and inconvenience to their families. Members of the staff have likewise served in dedicated fashion, in many instances above and beyond the normal requirements. Mr. James Slawny has adequately fulfilled his new role as Assistant Executive Administrator and has contributed much to a smoother working staff organization. Our best wishes go to Frances Zimmer who retired at the end of March.

Roger N. White  
*Executive Administrator*

## **DELEGATION TO THE AMA**

The Illinois Delegation to the American Medical Association for 1970 has completed a very busy and successful term. Breakfast meetings were held each morning the House of Delegates was in session and the cooperation of every delegate was excellent. Attendance at the annual meeting was 100% and only one delegate was absent at the clinical meeting. Two alternates were unable to attend the clinical meeting.

At the annual meeting of the AMA, the House of Delegates was in session for 17 hours and 15 minutes, during which time it considered a record 201 items of business, including 140 resolutions and 61 reports from the Board of Trustees, Judicial Council, Council on Constitution & Bylaws, Council on Medical Education and Council on Medical Service. At the clinical meeting, the House of Delegates was in session 10 hours and 50 minutes, during which time it considered 71 resolutions and 32 reports.

During the annual meeting, Dr. Harlan English served as Chief Teller; Dr. Jacob E. Reisch served on the Committee on Rules & Order of Business; Dr. Philip G. Thomson served on Reference Committee C, Medical Education; Dr. Edward Piszczek served on Reference Committee E, Scientific & Public Health. During the clinical meeting Dr. Maurice M. Hoeltgen served as Chairman of the Reference Committee on Amendments to Constitution & Bylaws and Dr. Harold Sofield served on the Reference Committee on Legislation, (B).

Dr. Walter C. Bornemeier of Chicago, Illinois, was inaugurated as President of the American Medical Association at the annual meeting in Chicago in June, 1970. In his inaugural address, Dr. Bornemeier cited five areas for improvement in medical education and training: shortening the medical school curriculum; modernizing and shortening residency programs; relating more medical training to patient care at an earlier point; assimilating full-time teachers into patient care; and reducing the number of medical research institutions and researchers.

In his presidential address to the House of Delegates at its clinical meeting in Boston, Dr. Walter C. Bornemeier reflected an aura of positiveness in his proposals of a leadership role to be taken by the AMA in the development of neighborhood medical clinics which are fast becoming the "focal point for delivery of most medical services." AMA leadership is vital, "so that we may insure that medical clinics remain a part of the private practice. The poor must have access to medical care on the same basis as most affluent citizens," Dr. Bornemeier stated.

Young physicians should be well advised and local medical societies should be involved in organizing and maintaining control of medical clinics. He emphasized that medical education should be shortened, ambulatory patient care be emphasized and that new MDs train at the side of experienced physicians in preceptorship programs.

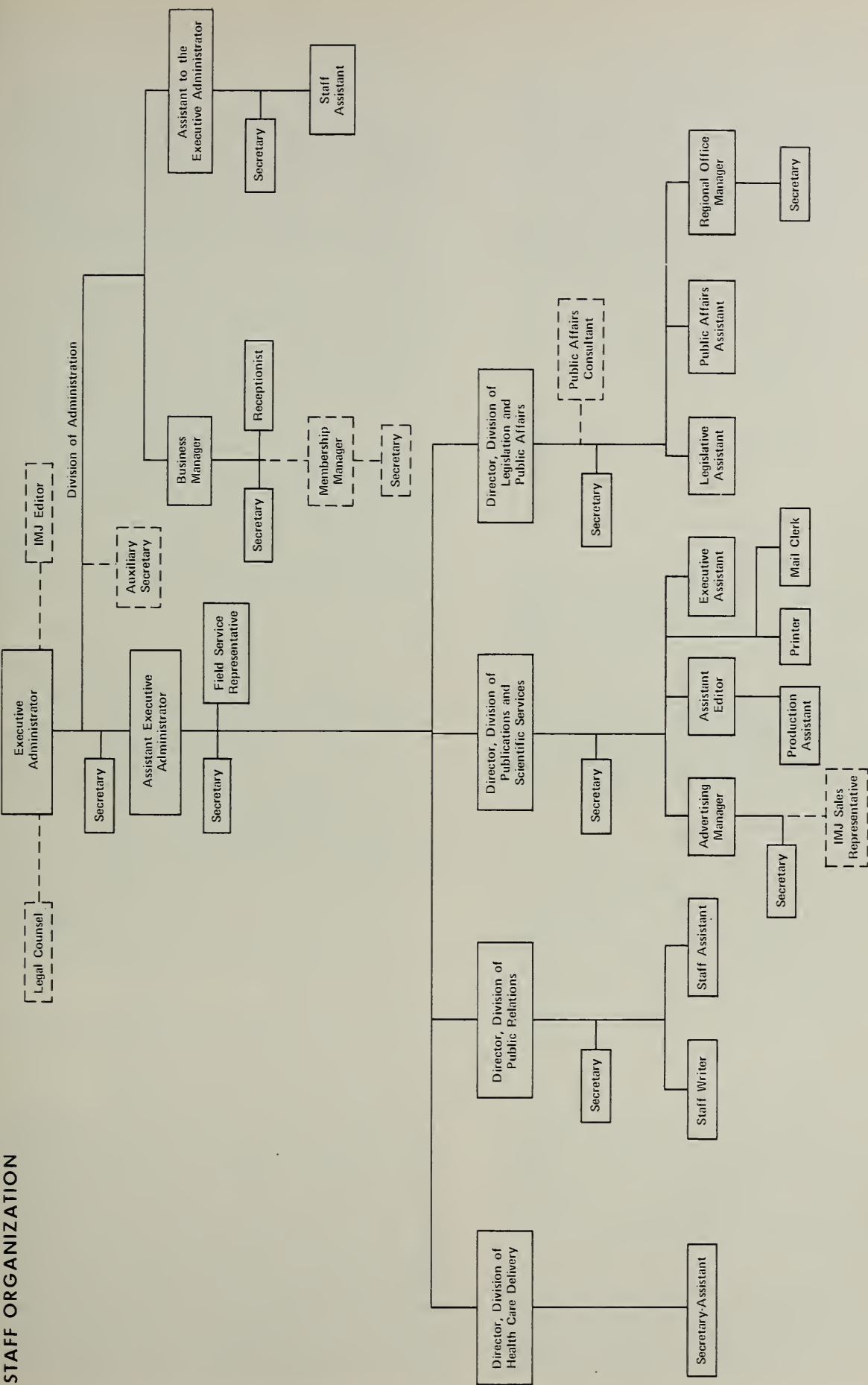
Dr. Bornemeier was highly commended for his penetrating analysis of the problems of medical education.

#### **Honors and News**

Dr. Charles B. Huggins, of the Pritzker School of Medicine, Chicago, was presented the Dr. Rodman E. and Thomas G. Sheen award at the annual session of the AMA meeting in June 1970.

*(Continued on page 370)*

STAFF ORGANIZATION



complement  
32 full-time  
7 part-time,retainer or contract (indicated by broken line)



## AMA Delegation

(Continued from page 368)

Dr. Henry Holle, Chicago, Delegate from the Section on Preventive Medicine and Medical Director of the Illinois Department of Public Aid, was awarded the Distinguished Service Award for 1970 at a meeting of the American Association of Public Health Physicians at their annual meeting in Houston.

Dr. J. Ernest Breed presented the AMA-ERF with a check from the Illinois State Medical Society for \$92,000.

Dr. V. P. Siegel, who has served on the Board of Directors of the American Medical Political Action Committee, received a plaque upon retiring from the committee.

The AMA Board of Trustees met during the Boston meeting and appointed Dr. Philip G. Thomsen a member of the National AMPAC Committee.

### 1970 AMA Resolutions and Action Thereon

The Illinois Delegation presented 8 resolutions to the AMA House of Delegates at the 1970 annual meeting in Chicago.

#65 "Promotion of the Private Practice Medicine"  
*Adopted*

#66 "Protection of the Public from Unwarranted Medical Statements" *Adopted*

#67 "Residency Training Periods"

Since representatives of both pediatrics and anesthesiology appeared before the Reference Committee and testified that the requirements for certification by the specialty boards in these two fields have not been increased, the necessity for this resolution did not exist.

#68 "Liaison with Hospital Boards"

The reference committee amended the resolution slightly and encouraged the hospital medical staff to purchase subscriptions to the *AMA News* and other appropriate publications for members of hospital Board Directors.

*Adopted as amended*

#69 "Paging Policy of the JAMA" *Referred to the Board of Trustees*

#70 "AMA/AMPAC Workshop—Washington, D.C." *referred to the Board of Trustees, as reference committee felt decisions of this kind in rapidly changing political scene should not be made by the House of Delegates meeting twice annually.*

#71 "AMA Physician's Public Affairs Council" *NOT adopted, since the House felt that this responsibility of the Board should not be diluted by delegation to a new committee, which would also result in additional expense.*

#88 "Hospital Reimbursement"

Called for AMA endorsement of reimbursement based on prospective rate negotiation with recommendation of this method to the Government agencies and Blue Cross. *Referred to Board of Trustees for transmittal to appropriate AMA Councils and Committees for their study and consideration.*

The Illinois Delegation presented seven resolutions to the AMA House of Delegates at the 1970 clinical meeting in Boston:

#24 "SAMA-MECO Project" relates to the Medical Education and Community Orientation Project of the SAMA. After hearing extensive testimony in support of this project, the Reference Committee felt the substitute resolution fulfills the intent and provides

a more appropriate position for the AMA at this time. *Substitute resolution adopted* (Below as APPENDIX I)

#26 "AMA Newsletter for Former Members of the House of Delegates" Requested that AMA newsletters be distributed to each former member of House of Delegates for three years following termination of their services. *Adopted with moderate amendment*

#27 "Ecology" encourage immediate efforts be initiated by health and education professions to establish educational programs in our schools, colleges and communities—on ecology, including human ecology. *Adopted*

#28 "Teacher Preparation in Health Education" requested AMA to reaffirm prior resolutions urging health education in American schools through the 12th grade, and to require teachers to qualify in health education for teacher certification. *Adopted*

#29 "Scientific Accuracy in Drug Abuse Education" pertained careful evaluation of scientific credibility of individuals and their sources of information, by medical societies, schools, and other groups and that all persons involved in the prevention of drug abuse continuously update their information—Third resolve amended to read: That the AMA cooperate with many organizations, agencies and individuals concerned with solving the problem of drug abuse by encouraging educational programs in each community. *Adopted as amended*

### APPENDIX I

RESOLVED, That the American Medical Association strongly support the principle of the SAMA-MECO Project as an important adjunct to undergraduate medical education; and be it further

RESOLVED, That the AMA recommend to its constituent state medical societies their endorsement and development of the SAMA-MECO Project in their state; and be it further

RESOLVED, That the AMA House of Delegates request the Council on Medical Education in cooperation with the Association of American Medical Colleges and the SAMA to study the SAMA-MECO Project and other extramural programs and consider whether they might be recommended to the medical schools for elective academic credit and make a report on this study to the House at its next meeting.

*Adopted*

#30 "Drug Abuse Education" describes critical problem of drug abuse in our society and urges renewed efforts to combat it.

*Adopted with minor amendment.*

#60 "Accidental Deaths due to Poisoning" (children) increasing greatly from ingestion of medications from bottles not protected by a safety cap. Resolved that the House of Delegates express strong approval of appropriate legislation requiring that all medicines be dispensed with child resistant closures, except as otherwise specified by the physician. *Adopted*

Resolution #12 introduced by the Pennsylvania delegation at request of Dr. Edward W. Cannady (Illinois), calls on the AMA for recognition of the contributions of homemaker services, advocates the expansion of home care programs, and urges support of the National Council for Homemaker Services, Inc. AMA is participating in the activities of the National Council through financial con-



tributions and supportive services. Dr. Cannady is the official representative of the AMA on the Executive Committee and Board of Directors of the National Council on Homemaker Services.

*Adopted with two minor editorial changes.*

During the week of the Clinical Meeting the ISMS Delegation had several guests: Mr. Rogert Redinger, Dr. John Troxel and Morton Adler and Mr. Walter Livingston from the Illinois Medical Service (Blue Cross-Blue Shield).

The Illinois Delegation is particularly indebted to the Illinois Medical Service for printing and supplying us with the directories again for the 4th time. They also sent flowers to the headquarters suite.

Other members of the AMA House of Delegates from Illinois who joined our delegation for breakfast meetings were: Drs. Henry A. Holle, from the Section on Preventive Medicine; James P. Ashtrom, Jr., from the Section on Orthopedic Surgery; Joseph L. Koczur, from the Section on Physical Medicine and Maynard I. Shapiro from the Section on Family Practice.

Dr. Walter C. Bornemeier, President of the American Medical Association, joined the delegation whenever he found it possible. Dr. George F. Lull, honorary member of the delegation, was present at all breakfast meetings. Other physicians in attendance included officers of the ISMS, Dr. J. Ernest Breed, Dr. L. T. Fruin, Dr. W. C. Scrivner, and Drs. William E. Adams, V. P. Siegel and Fred A. Tworoger. From SAMA: Messrs. Bruce Fagel, Lee Fisher, Michael Youssi, Ronald Ban and Donald Botts.

An unusual number of changes in the delegation will occur January 1, 1971, since the following members served at their last meeting in Boston:

Delegates: Leo P. A. Sweeney, Chicago

Seated in November of 1958 following the death of Warren W. Furey. He served as an alternate from 1957.

William K. Ford, Rockford

Has been a delegate since January 1, 1963.

Jacob E. Reisch, Springfield

Delegate since 1967 following election of Burtis E. Montgomery to the Board of Trustees. Served as an alternate delegate from 1960.

Alternate

Delegates: Allison L. Burdick, Sr., Chicago

Served as an alternate delegate from 1967 to date.

Arkell M. Vaughn, Chicago

Served as an alternate delegate from 1963 to date.

Paul A. Dailey, Carrollton

Served as an alternate delegate from 1961 to date.

New members of the delegation as of January 1, 1971:

Delegates: Carl E. Clark, Joseph Mallory, Francis W. Young

Alternate

Delegates: Frank J. Jirka, Jr., Boyd E. McCracken, William M. Lees, Fred A. Tworoger

The AMA Delegation received cooperation from the Board of Trustees for which they are grateful. Illinois Medical Service has given assistance in printing our directories and furnishing flowers for the headquarters suite at both annual and clinical meetings.

The ISMS staff has been of tremendous help in carry-

ing out plans for both meetings. The Executive Administrator and Assistant Executive Administrator have cooperated and assisted in the smooth functioning of the delegation and hospitality suite in such a fashion that Illinois has gained many friends among other delegations in the House. Mrs. Frances C. Zimmer, assistant to the Executive Administrator, for betterment of the delegation in its work, has been invaluable in planning, experience and advice on matters pertaining to the function of the delegation. Her recall of previous actions and decisions of the delegation has done much to form a cohesive group to represent the Illinois State Medical Society at the AMA conventions.

Your chairman wishes to take this opportunity to express his appreciation for the confidence placed in him by the Illinois State Medical Society—and to thank them for the wide experience and knowledge he has received during his service as their delegate.

William K. Ford, *Chairman*

## PRESIDENT OF THE WOMAN'S AUXILIARY

"Open your eyes and look for some man, or some work for the sake of men, which needs a little time, a little friendliness, a little sympathy, a little human toil. See if there is not some place where you may invest your humanity." This was the philosophy of Dr. Albert Schweitzer, the memento of a truly wise man. How well Illinois Auxiliary members have responded to the call of humanity will be reflected in this resumé of our year's work.

In May 1970, this administration undertook a twelve month journey. That journey is now rapidly approaching the finish line and it is with pride that I report on some of the highlights of our accomplishments.

Being concerned homemakers and mothers, physicians' wives seek, through the auxiliary of their husbands' profession, solutions to the social and health problems of their communities.

This year our task and our challenge has been to commit ourselves, individually or as a group, in whatever way we are able, to render service to our communities and to the medical profession.

As the year 1970 began, a popular concept was that responsible and dedicated citizenship would be the qualities most relevant to the 70s. Based upon this kind of commitment, our theme for the 1970-71 auxiliary year has been "THE FOURTH 'R'—RESPONSIBILITY with special emphasis on INDIVIDUAL RESPONSIBILITY."

Auxiliary members are often lay experts in matters pertaining to health. Through our own committees we conduct programs which yearly become more comprehensive and far-reaching in effect.

Illinois physicians' wives are fortunate in that we can be part of the answer toward solving some of the crucial health and social problems that exist in our communities. Our health education programs, called Package Programs, are as modern as the times which have created a need for them; they have indeed "matched us with this hour." Under the guidance of the AMA, the Package Programs were developed by our National Auxiliary and they are perhaps the most valuable of materials to have been prepared for the county auxiliaries, where the action is. They enable auxiliaries to launch community-wide programs on drug abuse, alcoholism, mental health, sex education, homemaker services, youth fitness, health careers, block mother programs, immunization, VD education and adult physical fitness.



Concern today for tomorrow has brought out the best efforts and talents of the members of the 39 county medical auxiliaries in Illinois. This year's program has covered many needs, but the greatest concern was placed on the following committees:

### Health Careers

Noteworthy is the excellent response given to the request of the AMA for an increased emphasis toward recruitment of health personnel in all categories.

Over the years, this has been and is one of our strongest committees. Each year students are graduated from our high schools without any type of specialized training for present day demands. County auxiliaries have seen a vast potential in promoting the education of these students in medicine and its allied fields.

Illinois medical auxiliaries have raised over \$100,000 for health-career scholarships and loans since 1952.

From 1952 to the present, the AMA Woman's Auxiliary reports a total contribution of almost \$5,000,000 for health career scholarships and loans.

Each calendar day finds between 1,800 and 2,000 persons in training for a health career as a result of medical auxiliary's financial support.

### AMA-ERF

Stressing the Loan Guarantee Program was a major request of the AMA and the National Auxiliary for 1970-71.

Who can better understand the need of funds for medical schools, loans to students, residents and interns than members of the medical auxiliary?

Auxiliary women in Illinois counties have demonstrated their commitment to and support of medical education by contributing more than \$100,000 to the Fund since 1951.

At this writing, county reports are not all in; however, indications are that the 1969-70 amount raised, \$11,183 will be equaled in 1970-71.

The AMA Woman's Auxiliary, through the combined efforts of county auxiliaries throughout the United States, reports a total contribution of \$4,000,000 to AMA-ERF in the past two decades. The Auxiliary presented a check for \$498,950.69 as its 1969-70 contribution to the American Medical Education and Research Foundation.

### Benevolence

One of the objectives of the Woman's Auxiliary to the Illinois State Medical Society is to encourage contributions to the Benevolence Fund.

Each year the total contribution of Illinois physicians'

wives to this Fund increases. We anticipate 1970-71 efforts to exceed \$8,000.

### Public Relations

Auxiliary members are reminded often that the problems of medicine in the future do not lie in the scientific but rather in the political and public relations area, and that is where the auxiliary functions best.

With outstanding programs carried out on the home front to foster health education, to work toward improvement of health facilities, to discover health needs and do something about them, the county medical auxiliary has achieved a high standing in the community thereby creating an improved climate of confidence in the medical profession.

### Membership

Old ideas were recalled often this year—in particular our state-wide membership campaign. The brochures developed by the 1969-70 state membership chairman—*Blueprints for Action* in building membership and *12 Reasons Why Auxiliary*—were reprinted for distribution to county auxiliaries again this year. New, however, are the brochures "eye-catching" covers designed by the 1970-71 membership chairman to enhance our state theme, "Individual Responsibility."

A popular word today is "communication," and the lack of communication is considered to be basic to all current problems. One writer underlines this when he says: "Only through communication are we saved from enmity toward one another."

Lack of communication among physicians' families is what prompted the organization of the first medical auxiliary, in the Oklahoma Territory back in 1907. One of the objectives of the auxiliary then and today is to cultivate friendly relations and promote mutual understanding among physicians' families.

To every physician's wife, the gift of auxiliary membership is yours. It is there to give you the opportunity to serve and through serving to receive the intangible rewards which will follow so surely.

One of the highlights of the year has been the organization of the Auxiliary to the Williamson County Medical Society. Through the enthusiasm and perseverance of one member-at-large, Mrs. Renato Souza, Southern Illinois claims this second new medical auxiliary.

To Dr. Breed, the Advisory Committee, and members of the Board, we express appreciation for your continued interest in our program, which is demonstrated by your encouragement and financial assistance.

Mrs. Wilson West, *President*

## Committees of the Board of Trustees

### ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

The President-Elect met with the Auxiliary at their meeting on October 30, and again with other members of the Committee at the luncheon meeting of the Auxiliary on January 16.

The Committee is impressed with the enthusiasm and interest of current and up-coming leaders of the Auxiliary. Their attention to potential broadening of the base of membership and further envelopment of present membership in leadership efforts would seem to augur well for the future.

The problem of liaison with and derivation of help from the Illinois State Medical Society office has resulted in an arrangement which should pay worthwhile dividends in the future. This entails the employment of a part-time secretary and the establishment of an office in Monmouth under the capable direction of Mrs. Robert Swanson. When this development has been consummated, the interest and activities of the Auxiliary should be thoroughly enhanced.

The Advisory Committee is grateful to Mrs. Wilson West, her team and the entire Auxiliary for their tireless efforts to support the Illinois State Medical Society in their activities and endeavors.

## COMMITTEE ON CONSTITUTION & BYLAWS

The following changes in the Constitution & Bylaws were referred to the Committee by either the House itself, or by the Board of Trustees.

Besides those items covered in the proposed changes, the committee was asked to consider three resolutions presented to the 1970 House of Delegates, two of them from Will-Grundy (70M-26 and 70M-27). In regard to resolution 26, which would change the name of the House of Delegates to State Medical Forum, the Committee on Constitution & Bylaws concurred in the opinion expressed by the Policy Committee in consultation with the Finance Committee that the proposed action was not in keeping with the dignity of the House. The Board of Trustees unanimously approved this opinion and therefore no change in the Bylaws was recommended.

Resolution 70M-27, would extend custodial duties to include the House of Delegates, as well as the Board of Trustees. The Policy Committee, in cooperation with the Finance Committee, also considered this request and reported that these proposed actions would be extremely cumbersome, not feasible, and were not in keeping with ISMS objectives. Therefore, the Committee on Constitution & Bylaws prepared no changes based upon this resolution. This was also approved by the Board of Trustees.

Resolution 70M-11 requesting affiliate status for the American College of Radiologists and representation in the House of Delegates was referred to the Committee on Constitution & Bylaws. The establishment of affiliate societies was held in abeyance until it could be reconsidered. Affiliated groups were approved and the first delegate from the SAMA will be seated in the 1971 House and exercise his right to vote.

It is the wish of the Committee on Constitution & Bylaws to re-introduce changes in the Bylaws to provide for House of Delegates representation from affiliate societies as follows:

### CHAPTER III. THE HOUSE OF DELEGATES

#### Section 5.

ADD: a new paragraph B as follows:

#### B. Affiliate Societies

(1) *Qualifications. Affiliate societies shall be those recognized specialty societies of Illinois.*

(a) *as may be recommended by the Board of Trustees and approved by the House of Delegates;*

(b) *whose membership is not less than fifty and derived from not less than twenty component societies of the Illinois State Medical Society;*

(c) *which maintain at least 75% membership in the Illinois State Medical Society;*

(d) *whose rules and regulations are not in conflict with the Constitution and Bylaws of the Illinois State Medical Society, and*

(e) *which desire representation in the House of Delegates.*

(2) *Representation. Affiliate societies shall be entitled to one delegate and one alternate delegate*

*in the House of Delegates, each of whom shall be a member of the Illinois State Medical Society.*

(3) *Term of Office. The term of office of a delegate shall begin January 1 following his election, and shall be for two years, or until his successor has been elected.*

Paragraph B now becomes Paragraph C

### In the Constitution:

#### Page 327 ARTICLE VIII. OFFICERS

In line four

STRIKE the word "sixteen" and  
SUBSTITUTE the word "nineteen"

so that it shall read:

*"The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide."*

### In the Bylaws:

#### Page 329 CHAPTER II. ANNUAL CONVENTIONS, Section 3. Paragraph B.

STRIKE the entire paragraph and  
SUBSTITUTE the following:

*"B. The Scientific program shall be implemented by the Committee on Scientific Assembly in cooperation with the Chicago Medical Society and representatives of specialty groups."*

#### Page 330 CHAPTER III. THE HOUSE OF DELEGATES. Section 9.

STRIKE the entire Section 9. (It will be provided for elsewhere).

#### Page 330 CHAPTER V. DUTIES OF OFFICERS. Section 1.

STRIKE the entire second and third paragraphs.

#### Page 331 In section 4 Paragraph 2

In line 6

STRIKE the words "the reference committees" and  
SUBSTITUTE the words: "all committees of the House of Delegates. He shall seek the advice of officers and trustees."

so that it will read:

*"He shall appoint all committees of the House of Delegates. He shall seek the advice of officers and trustees."*

#### Page 331 In Section 5.

Lines 3 and 4

STRIKE the words: "or inability of the speaker to perform his duties"

In line 3

SUBSTITUTE after the word "death"  
the word "or"

after the word "resignation" the words  
"of the speaker"

so that it shall read:

*Section 5. The Vice Speaker. The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death or resignation of the speaker, the vice speaker shall serve during the unexpired term.*



Page 331 CHAPTER VI. THE BOARD OF TRUSTEES  
Section 1. *Composition.*

In line 2,

STRIKE the word "sixteen"

SUBSTITUTE the word "nineteen"

In right hand column:

In line 1

STRIKE the word "six"

SUBSTITUTE the word "nine"

In lines 2, 3, and 4.

STRIKE the words "each of the other ten districts, (see map attached), these districts of the geographical areas as of May, 1946],

SUBSTITUTE the words "nine shall be chosen from the Third Trustee District and one from each of the other ten trustee districts of the State as delineated by action of the House of Delegates, May 1946."

so that it will read:

*"Section 1. Composition. The Board of Trustees shall consist of nineteen trustees elected by the House of Delegates, nine shall be chosen from the Third Trustee District and one from each of the other ten trustee districts of the State as delineated by action of the House of Delegates, May 1946 . . ."*

Page 332 CHAPTER VI. THE BOARD OF TRUSTEES,  
(cont.)

Section 6. *Quorum.*

In line 1

STRIKE the word "Ten"

SUBSTITUTE the word "Eleven"

In line 2

Following the word "Trustees"

ADD the words: "from at least seven trustee districts"

so that it will read:

*Section 6. Quorum. Eleven members of the Board of Trustees from at least seven trustee districts shall constitute a quorum for the transaction of business.*

#### Correction of 1970 Copy:

Page 332 In the second column under

Section 10. Second paragraph, lines 3, 4 and 5.

STRIKE the words "Ethical Relations Committee, Grievance Committee and Prepayment Plans and Organizations Committee."

INSERT the words: "all district committees"

So that it shall read:

*"Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees."*

Page 333 Second column, Under CHAPTER IX

Part 1. Councils and Committees, should appear in all capital letters.

Part 1. COUNCILS AND COMMITTEES.

PART 2. COUNCILS.

Page 334 Right hand column

Section 4 should be Section 3. *Duties (Areas of Concern)*

Page 335 CHAPTER IX. COMMITTEES

Section 5.

STRIKE the entire Section 5. *Reference Committees.*

Part 3. House of Delegates should be in caps.

PART 3. HOUSE OF DELEGATES COMMITTEES.

Section 1. Should be set to agree with other type. (upper and lower case).

Page 336 Section 2. *Ad hoc Committees* In line 1

STRIKE Section 2.

SUBSTITUTE Paragraph "I"

In paragraph D, line 2

STRIKE the words "more than three years" and

SUBSTITUTE the words "one year"

so that it shall read

*"Ad hoc committees expected to serve for one year shall be reorganized and given the status of a sub-committee or special committee under the appropriate Council, and should be appointed by the Board of Trustees."*

Under "Paragraph I", the sub-paragraphs should be renumbered so that

Paragraph A. becomes paragraph 1

Paragraph B becomes paragraph 2

Paragraph C becomes paragraph 3

Paragraph D becomes paragraph 4

Paragraph E becomes paragraph 5

Page 337 Right hand column

CHAPTER X. COUNTY SOCIETIES. Section 9

In lines 4 and 5

STRIKE the words "fifteenth of January each year" and

SUBSTITUTE the words "first Wednesday of January each year"

so that it shall read:

*Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the first Wednesday of January each year.*

Page 340

PART II Should be PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES.

(misuse of Roman numerals)

If it becomes necessary to file a supplementary report, the material will be made available at the opening of the House of Delegates.

Charles K. Wells, *Chairman*

Fredric D. Lake, *Co-Chairman*

Arthur F. Goodyear

Frank J. Jirka, Jr.

Paul W. Sunderland, *Ex-Officio*

Frank M. Pfeifer, *Consultant*

## EDUCATIONAL AND SCIENTIFIC FOUNDATION

The Educational and Scientific Foundation of ISMS was established in 1961. The Foundation is incorporated in Illinois, and financial support is tax deductible. The Foundation is dedicated to the advancement of medical knowledge and the education of the public, particularly in the State of Illinois. A Board of Directors, which consists of the ISMS President, the immediate Past-President, the Secretary-Treasurer and the Chairman of the Board of Trustees, manage the Foundation. The immediate Past-President serves as Chairman of the Foundation Board and the Secretary-Treasurer of the Society occupies the same post in the Foundation. There are three classes of membership in the Foundation:

- 1) Fellows of the Foundation are physicians holding regular membership in the Foundation following the contribution of \$100 or more.
- 2) Associate fellows are non-physicians holding regular memberships in the Foundation following a contribution of \$100 or more.
- 3) Honorary fellows are individuals whom the Foundation's Board of Directors elect to membership because

of their exceptional service to the organization and its goals.

During the year, the Foundation served as a receiving and disbursing agent for these educational projects:

- 1) SAMA-MECO summer job-education project from unrestricted funds.
- 2) Updated covers for Illinois Medical Journal.
- 3) Shared cost of new human manikin at the Chicago Museum of Science & Industry from publications improvement fund.
- 4) Operation of a task force on physician shortage from a fund for unmet medical needs.
- 5) Scientific Speakers Bureau from a grant from Merck, Sharp & Dohme.

The following county medical societies used the service in 1970; Bureau, Coles-Cumberland, De Kalb, Du Page, Franklin, Greene, Knox, La Salle, Lee-Whiteside, Livingston, Montgomery-Macoupin, McLean, Peoria, Stephenson and Vermilion.

In January, the Foundation received \$3,000 from Merck Sharp & Dohme to operate the Speakers Bureau in 1971. This amount is \$2,000 less than the Bureau has had for the past several years and county societies utilizing the Bureau's services are advised to limit their requests for reimbursement of speakers' expenses.

The Board also voted to support the following projects in 1971:

- 1) Medical self-testing during the 131st annual meeting
- 2) Production of a brochure on Hospitalization of the Mentally Ill to be published by the ISMS Council on Mental Health and Addiction.
- 3) A Membership Opinion Survey.
- 4) SAMA-MECO Project in cooperation with the Illinois Hospital Association.
- 5) A feasibility study of foundations for medical care.

The Foundation gratefully acknowledges individual gifts received throughout the year and encourages members of the Illinois State Medical Society to remember the Foundation in providing bequests in wills and in making charitable contributions.

## COMMITTEE ON OSTEOPATHIC PROBLEMS

Since there have been no problems in this area, there has been no necessity for the committee to meet.

Arthur F. Goodyear, *Chairman*

Eugene P. Johnson                      Fredric D. Lake  
Frederick E. Weiss

## COMMITTEE ON HEALTH CARE FINANCING

During the past year, the Committee on Health Care Financing (formerly called Committee on Usual & Customary Fees) was active in two important areas: as ISMS liaison to the Illinois Department of Public Aid; and the complex assignment of examining the various health care foundation concepts to determine which might be best suited for Illinois. The Committee's final recommendation to the Board of Trustees on the latter question is still to be determined as this report goes to press.

Since last summer, it became apparent that the foundation question was becoming increasingly important. The Committee felt ISMS leaders should get as much information on foundations as possible.

A special Leadership Conference was planned in November, and presented in cooperation with the Committee. A record turnout of 425 physicians and other interested persons from all parts of Illinois attended the Conference. Experts from the various health care foundations, plus spokesmen from government, hospitals and the health insurance industry, brought ISMS leaders the latest information on the drastic changes being proposed

in health care delivery. Committee members participated in the Conference as reactor panelists.

On several other occasions during the year, the Committee met with representatives from major health care foundations in an attempt to learn as much as possible about other kinds of foundations before suggesting which type will be best suited for Illinois.

In their continuing efforts to give local physicians every opportunity to express their thoughts on health care foundations, the Committee obtained Board approval to employ three highly regarded foundation experts. This trio, accompanied by staff, spent a week traveling to key areas of the state. The Consultants obtained ideas and reactions of local leaders. This information was utilized to prepare a report that will be considered by the Committee. Based on this report, the Committee will draft a final recommendation to the House of Delegates.

In its activities with Public Aid, the Committee considered several problems regarding IDPA payment policies. Most of these problems involved complaints from physicians about IDPA's reducing fees, or the length of time taken by IDPA for processing claims.

The Committee did obtain agreement from IDPA for the latter to reappraise its mileage payment policy to physicians in rural areas. The former policy, payment of 50 cents per mile after the first five miles, was deemed inadequate by the Committee. IDPA agreed to consider paying physicians total one way mileage from the city limits of their communities to the homes of their patients.

Discussions were also held with IDPA about the Department's reference to ISMS' fee survey in letters to physicians. ISMS had objected to this practice because it implies that IDPA blamed the fee survey for the Department's payment practices. Mr. Harold O. Swank, deputy IDPA director, told the Committee that in all future letters to physicians from the Department, the reference to the ISMS fee survey would be deleted.

In reply to an ISMS request (Resolution 70M-23)—the department agreed to permit persons other than physicians (in groups or clinics) to sign claim forms.

This report is submitted for information only and no action is required by the reference committee.

Joseph R. O'Donnell, *Chairman*

James B. Hartney                      Eugene P. Johnson  
Frank J. Jirka, Jr.                      Joseph L. Bordenave  
Frederick E. Weiss                      Jacob E. Reisch, *Consultant*

## POLICY COMMITTEE

During the past year, the Policy Committee has considered the resolutions referred to it by the House of Delegates pertaining to dual responsibility of the House with the Board of Trustees for (1) property of the society; (2) allocation of funds and priority of budget items; and (3) a change of name and function of the House of Delegates.

The proposed actions were considered to be cumbersome, not feasible and not in keeping with ISMS objectives. The Board of Trustees unanimously approved the Committee's findings.

The Policy Committee also took under advisement the matter of hospital records being requisitioned by third party agencies, especially Social Security Administration for Medicare patients. Inasmuch as the patient on Medicare does, in fact, sign a release of record information when admitted to the hospital, it was felt that no change in the Policy Manual should be made at this time. The Committee and the Board of Trustees were later assured by Blue Cross, our Medicare carrier, that records were scrutinized only by professional personnel (RNs or MDs) and were therefore confidential.

Joseph L. Bordenave, *Chairman*

James B. Hartney                      William A. McNichols Jr.



## PUBLICATIONS COMMITTEE

In 1970 the Publications Committee, in addition to its usual planning and activities, initiated a new two-year or two-directional project—for improvements in the quality, design and format of the *Illinois Medical Journal* and the "Pulse." While these two publications have been well received by both the membership and members of the pharmaceutical industry, it was felt that design changes and modernization would lead to an even greater readership and provide a convenience factor in identifying articles of special interest.

Internal modifications for the *Journal* included more specific sectionalization with upgrading and modernizing of the mastheads. This was accomplished with the January, 1971, issue. The new mastheads are in abstract form, but all are designed with a general overall uniformity in style. A change was made in column widths; a slight increase in width with a minor decrease in depth allowed a more horizontal appearance which, while giving more white space, actually allowed for more copy on a page. The overall appearance was thereby enhanced and articles were presented more clearly and more legibly. Some changes were made in type styles. Article headings are gradually being changed to variants of three crisp and sharp fonts rather than a hodgepodge of many different typefaces. Gradually, as make-up and costs permit, more tint blocks (color pages) are being added to add emphasis as well as designate certain departments. The ultimate of the printed page is to have it appear interesting, clear, balanced and easily readable; in a word, inviting—with-out the reader being aware of why he is attracted to a page.

"Pulse" has likewise been revamped. In addition to using the same changes developed for the *IMJ*, a new paper stock and color are being used. By so doing, a three-color effect can be obtained in many instances (instead of two-color, as in past years). Also, "Pulse" is being printed by offset, which provides a "softer" appearance and permits the use of more photographs without cost increase. It is of vital importance that "Pulse" be kept top-notch, both in news appeal, content and appearance so that the contract for its sponsorship will continue to be renewed.

All of this is essentially Part I of the project and has, in the main, been accomplished. The second half has to do with a critical analysis of the content of the publications—what the membership likes and doesn't like, wants and doesn't want, how well they are or aren't read, and why. This will be discussed under "Readership Survey."

### Advertising

In 1970, the year began very promisingly with early advertising revenues exceeding anticipation. As the year progressed, it seemed that budgeted amounts would be exceeded. However, the crises in the stock market apparently cooled the economy to the extent that the October and December issues fell far short. As a result, the anticipated advertising revenue was not met. We were short 1% of the \$125,000 budgeted. Again, the year 1971 has started out with great promise. A projection for the first six months, based on contracts in hand, indicates that there is every reason to expect that budgeted amounts will be achieved. It is the second semester, however, that is treacherous. From repeated experiences, we can only say we hope there will be no major changes downward during this period in 1971.

In an overall aspect, it is most evident that the *Illinois*

*Medical Journal* has been accepted as a prime state journal for advertising by the pharmaceutical industry. Audits of other state medical journals indicate a far greater use of *IMJ* by medical vendors than other states of comparable size. We believe this indicates that not only is Illinois a major medical market but also that the *IMJ* is a quality publication.

Advertising rates remain unchanged for 1971. Since there was an increase for 1970, the advertisers were most grateful that ISMS was holding the line in trying to control increases in costs. This was accomplished in the face of increased second class mail rates and other increases in production costs. A very critical review of this will be made during 1971, to ensure that the *Illinois Medical Journal* does not incur too large a deficit and to reach a decision concerning 1972 rates.

Membership in the Association of Industrial Advertisers, "AIA," has benefitted the *Illinois Medical Journal* to a great extent. We are the only state medical journal listed by the Association of Industrial Advertisers and displaying logotype of AIA. The extensive fact sheet developed for the membership application has proved to be one of the most successful sales tools ever conceived for our *Journal*. In addition, several promotion items for the *IMJ* have been utilized. In 1970, a magnetic paper clip holder for desk use, prominently displaying the logotype of *IMJ*, was used and distributed to media directors and agency people. In late 1970, a jumbo ball point pen with an advertising message promoting the *IMJ* was also distributed. While of minimal cost, such items help our staff and sales representative immensely in the keen competition for advertising.

Advertising policies have continued essentially unchanged during 1970. During the course of the year the ethical proprieties of several kinds of advertising have been discussed. The committee reviewed these matters with great interest and detail and accepted only such advertisements as were appropriate for the *Illinois Medical Journal*.

### Subscription Rates

Subscription rates for the *Journal* have remained unchanged for several years. It is to be noted that the cost of the subscription does not meet publication expenses. However, the Publications Committee feels that the present dues allocation is sufficient to guarantee the funding necessary to cover the expenses of the *Journal* not met by advertising revenue. In no way does the Illinois State Medical Society realize any profit on the *Journal*; however, it is almost exactly a self-supporting activity as far as direct production costs are concerned.

### Reference Issue

In past years the Reference Issue, published each fall, has come to be quite an important part of the ISMS communications program. Each year it has been furnishing more and more information. This has required a gradual increase in the number of pages for each such issue. With increases in paper cost and printers' charges, it was felt that some economies needed to be effected for the 1970 issue. Therefore, approximately 40 pages (or 15%) were removed in the October, 1970, issue. This reduction in no way affected the quality of the material presented since the only things eliminated were seldom used items such as listings of hospitals and nursing homes. This reduction resulted in an economy of approximately \$4000 in the printing cost of that particular issue.



### **"What Goes On"**

The 1970 House of Delegates suggested attempts be made to revive "What Goes On." Actually, efforts to do this have been ongoing since that publication was discontinued by the sponsor well over two years ago. During the past year renewed attempts to secure a pharmaceutical sponsor have been unsuccessful and it also has been impossible to interest any educational institution or governmental agency in doing likewise. Since it has been impossible to reestablish "WGO" as an independent publication, the Publications Committee has set aside a specific portion of each issue of the *Journal* to carry Continuing Medical Education News in a revived "What Goes On" format. This was inaugurated with the February, 1971, issue. All segments of the Society are urged to cooperate so that this might be a full listing of events.

### **Readership Survey**

Many advertisers and advertising agencies have been inquiring about readership and acceptance of *IMJ* and "Pulse." They want to know that their advertising dollar is being well spent. The best means of answering that question is through a readership survey by an independent agency. The Publications Committee received several opinions on how such a survey might be effectively conducted and has contacted possible firms capable of accomplishing this. The discussions resulted in a decision of the Publications Committee that such a survey should be undertaken by an independent auditing firm, and should be taken in the spring of 1971, for the development of the fall *IMJ* advertising kit.

The Publications Committee, therefore, requested authorization from the Board to conduct such a survey. This has been approved and as of this writing the Committee is in the process of setting up the mechanics for the survey which will be done in the next two or three months.

### **Incorporation of IMJ**

Under consideration for some time has been the possible incorporation of *IMJ* and other Society publications. This has been discussed with legal counsel at some length. Such a step might be necessary (or at least desirable) due to recently changed regulations of the Internal Revenue Service. At this writing, it is being held in abeyance with no action currently contemplated.

### **"Peer Reviewer"**

One of the important activities of the new Committee on Health Care Financing is speedy communication with local Peer Review Committees. This is to be done through the "Peer Reviewer," an information and fact sheet published at quarterly intervals. In order to acquaint the entire membership with this activity, a facsimile of each mailing will be carried in the *IMJ*.

### **Continuing Features**

Within the pages of the *Illinois Medical Journal* can be found many articles of clinical interest and didactic value. These represent approximately 40% of the pages carried during the year. Another 40% is given over to advertising. The remaining 20% is devoted to continuing features and special articles providing definite service to the membership—the non-clinical or "Business" aspects of the practice of medicine. These include the President's Page,

Socio Economic News, Practice Management News, Public Affairs Library, Membership Forum, Doctor's Library, and so on. Abstracts of Board Actions are reported regularly (five times during the year), so as to keep the membership informed of official activities of the State Society.

On balance, the *Journal* has remained as close as possible to this established ratio. This is important in maintaining the *Journal* as not only a house organ, but a truly worthwhile extension of the prime purpose of the Medical Society—education.

### **Increased Circulation**

A 1970 House of Delegates action directed that the *Illinois Medical Journal* and the "Pulse" be sent to all SAMA members, interns and residents in 1971. At the time of this action, the information was that this would involve approximately 1500 additional copies of each publication and an assessment of \$2.00 per member was levied to cover the estimated cost.

In implementing this action, it was found that the actual number of such individuals was 3356. Mailings to all of these individuals began with the January, 1971, issue and continued during the next two months (February and March). However, because of cost limitations, a change was necessitated for the remainder of the year. Starting with the April issue, each publication will be mailed to all SAMA members (about 850) and will be continued through 1971. The interns and residents were placed on a rotating basis so that each month one-third will receive copies. Since there has been no rejection of the assessment, it appears this will be fiscally sound.

The Publications Committee is convinced of the value (and need) of continuing this educational endeavor and feels that such Society contact with all three groups is mutually beneficial. However, if this policy is to be continued, the special assessment will have to be increased from \$2.00 to \$4.00 to cover the 3356 copies (instead of 1500) and increases in paper and printing costs, as well as the increased postage rates.

### **Staff Organization**

At the end of 1970, realignment of some of the activities within the headquarter's office resulted in the Publications Division again being combined with the Division of Scientific Services. The new division includes all that was formerly under the Publications and Scientific Services Division as well as Medical Legal Activities. Thus, all activities of a scientific or educational nature fall within one division. This should result in an improved service to the membership and better coordination of these activities. This division now furnishes all services for the headquarter's office in printing, publishing, reproduction and mailing as well as staffing four Councils and 15 committees.

### **Thank You**

The committee offers its thanks to everyone who has assisted in the work of publications during the previous year. Without the support of the membership the *Journal* and the "Pulse" would not be what they are today.

Jacob E. Reisch, *Chairman*

A. Edward Livingston

Warren W. Young

### **EDITORIAL BOARD**

During the past year, the Editorial Board has met to



consider the editorial content of the *Illinois Medical Journal*. Our esteemed editor, Dr. Theodore R. Van Dellen, has very adequately reviewed the many medical manuscripts presented for publication in the *IMJ*. These have in the main been totally unsolicited. The Editorial Board has offered its assistance and advice to Dr. Van Dellen when problematic articles have been submitted.

It has been emphasized by the Editorial Board that the *IMJ* is in no way competing with *JAMA* or the *New England Journal of Medicine*. Emphasis on clinical content is aimed at the general practitioner as well as the specialist who is trying to gain a broad perspective.

It is possible that the *Journal* could be a medium for publishing articles from various clinical meetings held in Illinois. The staff will maintain an awareness of these meetings to try to solicit papers when such are of an exemplary nature.

Physical attractiveness of the *Journal* has been appreciated by this Board. The cover design alone has been deemed of such quality that it enhances the *Journal* and encourages readership.

It is hoped that new progress in any specific specialties could be reported in the form of editorials. The idea has been supported that readers must be made aware of current progress in specialties through our publications. Medical progress articles each month should deal with a different specialty. The membership is encouraged to submit editorials and articles.

Our several continuing medical features, such as the View Box, have been cited as good examples of highlighting specific items. A new medical specialty, the ECG of the month, has been well received. Surgical Grand Rounds has continued in extremely good fashion. It has been stressed that the purpose of these many didactic items is to keep our readers aware of what is going on in medicine today.

Many new topics and concepts have been proposed for inclusion as articles and these will be worked up as authors are obtained. A series may soon be included on maternal morbidity and mortality protocols in cooperation with the Committee on Maternal Welfare. Some specific areas which have been weak and are being strengthened are the fields of anesthesiology, orthopedics and trauma medicine.

The chairman wishes to thank the members of the Editorial Board for their interest and support during the year.

He particularly commends the editor, Dr. Van Dellen, and the four contributing editors for their wholehearted support and perseverance during the year.

This report is for information. No action is required.

Frederick Steigman, *Chairman*  
Theodore R. Van Dellen, *Editor*

William E. Adams	Thomas J. Collins
Arthur DeBoer	Newton DuPuy
Edward DuVivier	L. Martin Hardy
Joseph H. Kiefer	Clarence J. Mueller
Robert E. Lane	Arkell M. Vaughn
Ernest Lowenstein	Alon P. Winnie
David Shock	Donald L. Unger
Donald L. Unger	Alon P. Winnie

*Contributing Editors*

Harvey Kravitz	Leon Love
John M. Beal	John R. Tobin, Jr.

Neil Allen, *SAMA*

## EDITOR, *IMJ*

Innovative best describes the past year's *Illinois Medical Journal*—both editorially as well as the physical appearance. Questioned before an Editorial Board meeting on the present direction of the *Journal*, I explained that one should keep in mind that as a State journal, the *IMJ* should not be compared to the *Journal of the American Medical Association* or the *New England Journal of Medicine*. Instead, the *IMJ* should function as a medium of information, providing the Illinois practicing physician with information of a clinical nature as well as the business angle of health care delivery, e.g. medical-legal news, practice management and economics. In addition, I suggested that in maintaining the *Journal* as a relevant medical publication, new progress in specific specialties might best be reported in the form of an editorial. I, in turn, encourage readers to contribute to these "editorial-progress" reports.

During the past year, the *Journal* has maintained the necessary 40:60 per cent ratio of advertising to editorial. The majority of articles that appeared during the year were unsolicited and provided primarily by physicians from the Downstate area. A total of 44 clinical articles was published, covering subjects in the major specialties, particularly in internal medicine, psychiatry and OB-BYN. Medical progress articles appeared six times and dealt with such timely topics as "The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease," as well as "Contemporary Practices in Ophthalmology," the latter article eliciting a great response from readers for bibliographic material. In addition, 24 special articles relevant to such issues as peer review, pollution, public health and medical-legal information diversified the content greatly. The popular monthly feature, "Surgical Grand Rounds," added 11 presentations to the list of clinical material.

In attempting to relate the business side of health care delivery to our readers, "Practice Management News" (written by Robert P. Revenaugh, of Professional Business Management) and "Medical Legal," (edited by ISMS legal counsel Frank M. Pfeifer) were added as new features. "EKG of the month," edited by Drs. John R. Tobin, Rimgaudas Nemickas and Patrick Scanlon, of Loyola University Stritch School of Medicine, follows the quiz-and-answer format of the successful "Viewbox," edited by Dr. Leon Love.

The staff has endeavored to maintain and upgrade the *Journal* as a medical-educational publication—their continued cooperation is appreciated. In addition, I would like to thank contributing editors, Dr. John Beal, "Surgical Grand Rounds," and Dr. Leon Love, "Viewbox" for their support each month, and over the years. Also the contributing editors of "EKG of the month."

An important cog in the wheel of producing the *Journal* is, of course, staff. The Medical Society, I am sure, would want to thank in particular the individuals who have worked tirelessly and innovatively in getting our *Journal* out every month. Mr. Richard Ott, Managing Editor, Mr. John Kinney, Advertising Manager, and Mrs. Michaelyn Sloan, Assistant Editor, have each done much to maintain the *IMJ* as a truly good publication.

T. R. Van Dellen, *Editor*



## TASK FORCE ON COMPREHENSIVE HEALTH PLANNING

Report not received at time of publication.

V. P. Siegel, *Chairman*

Thomas P. deGraffenried

John Howard Kendall

Fred Z. White

*Consultants*

Clarke Mangum

Clifton Reeder

Philip Lynch

E. A. Piszczek

Frank J. Jirka, Jr.

Thomas Harwood

## TASK FORCE ON PHYSICIAN SHORTAGE AND SERVICES TO MEDICALLY DEPRIVED AREAS

During the past year, the Task Force on Physician Shortage assembled a compendium of financial assistance programs available to Illinois medical students to guide us in our recommendations to the Board and to answer inquiries from prospective medical students.

Concerned over the increasing shortage of family physicians, we also obtained progress reports from Illinois' six medical schools on their proposed plans to establish departments of family practice. Their responses follow this report.

However, we concentrated the bulk of our efforts in implementing three directives from the 1970 House of Delegates. They were:

- Establish a liaison program with residents and interns;
- Co-sponsor a Chicago-based health care center with the Chicago Medical Society and the American Medical Association (Resolution 70M-51);
- Establish a loan program for inner city medical students. (70M-44)

### Residents and Interns

In implementing the first directive, we were instrumental in having a Cook County Hospital resident appointed to the Task Force; ISMS assistance was offered to residents and interns who wish to establish a formal, state-wide organization. With efforts underway to create a national R&I association, the young physicians probably will need staff and financial assistance in organizing state-wide. ISMS stands ready to help.

When such state organization is established, we will enlist help in ameliorating the shortage and maldistribution of physicians in Illinois. Meanwhile, the Task Force is considering a motivation study of Illinois residents and interns to determine what motivates them in their choice and location of practice.

### Health Care Center

The Task Force also was directed to cooperate with the Chicago Medical Society and the American Medical Association in the establishment of a Chicago health care facility to provide medical services to the disadvantaged (Resolution 70M-51).

ISMS representatives met last July with CMS, AMA and the Cook County Physicians Association and chose Chicago's Kenwood-Oakland area for the project. Rather than construct a building to house the services, it was decided to purchase two mobile units which would travel throughout the Kenwood-Oakland area on a fulltime basis.

The vehicles, purchased by the AMA at a total cost of \$50,000, include an immunization-health education

mobile unit and a diagnostic-treatment unit. Members of the Cook County Physicians Association will staff the vehicles, which are expected to be in operation this summer.

### Inner City Student Program

Our most important project was the implementation of Resolution 70M-44, which directed ISMS to appropriate monies through this Task Force to develop a loan program for Chicago's inner city students in return for their practicing in the inner city after training.

In weighing the advice of several community organizations we concluded that—instead of gambling on an entirely new program of financial assistance—it would be more prudent to invest in an existing project that already enjoys the support and cooperation of inner city residents and organizations; that is the Urban Doctors Program.

The Urban Doctors Program (UDP)—described in detail in this issue of *IMJ*—is a partnership between Northwestern University Medical School, the Central YMCA Community College, and four inner city recruiting agencies. Its objective is to develop people from the poor neighborhoods into physicians for those communities by:

1. Identifying well-motivated high school graduates from those communities;
2. Financing their education for two or three years at a community college;
3. Securing admission to a Chicago medical school for those who complete their training.

While only Northwestern Medical School is currently involved (they expect to enroll 25 UDP students in September, 1972), all Illinois medical schools are expected to eventually participate. AMA recently acknowledged UDP's excellent work with a \$10,000 grant.

Since UDP embodies all the characteristics of a potentially successful program—and its potential to grow state-wide appears excellent—the Task Force will study it with the view of implementing Resolution 70M-44 by recommending ISMS financial support to it.

This report is for information only. No action needed.

William M. Lees, *Chairman*

Philip G. Thomsen

Jack Gibbs

Morgan Meyer

Eugene Johnson

Robert Freeark

Thomas A. Reardon

Alfred J. Faber

Matthew B. Eisele

Donald Stehr

Andrew Brislen

*Consultants*

James B. Hartney

George Shropshear

## LETTERS ON FAMILY PRACTICE

Dear Dr. Scrivner:

I am most pleased to respond to your inquiry concerning the matter of Family Practice. As you know, this institution was in the forefront of developing preceptorships in family medicine with the DuPage County Medical Society. This has been so successful in the past three and one-half years that it now includes Will and Grundy County in its boundaries.

*I will not belabor the point, since the details are well known to you, but we have had very little financial help from the State Society in this regard.* I was able to get



a grant from the Family Health Foundation and have found no sources of money in the federal government for this most important program. The third annual dinner of the program was held in DuPage County, and certificates were awarded to 100 practitioners who are involved, about forty of them most actively.

We also have formally established a Department of Family and Community Health in the medical school. Our main teaching hospital has yet to vote upon a similar department there, and I have reason to feel that this will soon be a reality. I am going to recruit a chairman and others to this department. As is commonly heard, we have serious budgetary restrictions and it is a formidable task to begin a new area with no funds either available or potentially so. If we are to make this a real peer department and attract students to the concept, money must be found to develop the kind of program necessary.

We are doing everything possible to respond to this issue for our State—not only in regard to the family practitioner but general manpower. Our building grant application has been moved up the line with high approval and now awaits final conclusion by the Secretary of the Department of Health, Education, and Welfare.

Please be assured that we are attempting to respond to this important issue of medical manpower for Illinois.

Sincerely yours,  
LeRoy P. Levitt, M.D.  
Dean, Chicago Medical School

Dear Dr. Scrivner:

In reply to your communication concerning plans to establish a Department of Family Practice at Northwestern University.

At the moment, we do not have plans to establish an autonomous Department of Family Practice. We have had discussions concerning this possibility but do not believe it is indicated. On the other hand, we are more interested in discussing some sort of an interdisciplinary coordinated effort to provide appropriate training for family practice. Whether or not this activity could be held within our new Department of Community Medicine, for which we are currently seeking a chairman, or whether it would be an interdisciplinary committee, remains to be seen.

We are sympathetic with the needs in this area but have not yet been able to identify the manner in which we will come to grips with it. If we have positive developments within the near future, I will let you know.

Sincerely yours,  
James E. Eckenhoff, M.D.  
Dean, Northwestern Univ. Medical School

Dear Dr. Scrivner:

The Office of the Deans and the Faculty of Rush are, at present, working vigorously on the content and structure of our educational program. The area of Family Practice is currently the subject of intensive discussion. There is no question that the production of practicing physicians will be a major goal of the reopened Rush Medical College, but it is too early to be able to answer the specific question regarding a Department of Family Practice.

Cordially,  
John S. Graettinger, M.D.  
Associate Dean, Rush Medical School

Dear Dr. Scrivner:

Our school established a section on family practice in the Department of Community & Family Medicine sometime ago. It is established as a section, rather than a distinct department to allow it to interact primarily with our teaching program in overall medical care delivery systems (community medicine). Family practitioners have been active in our teaching program for some time. A number of qualified family practitioners are on our hospital staff.

Its growth and development is dependent, at least in part, by appropriate funding. We would hope eventually that it will be a self-sustaining unit. I would hope that the legislature is cognizant that our medical school is very specifically interested in this area and does need their commitment.

Sincerely,  
Walter S. Wood, M.D.  
Chairman & Professor  
Community & Family Medicine  
Loyola University Stritch School of Medicine

Dear Dr. Scrivner:

I am pleased to know of the continuing interest of the Board of Trustees of the Illinois State Medical Society in the problem of providing adequate medical care throughout the State. The decline in the number of physicians declaring themselves to be family practitioners has been occurring over the past several decades. Many people have speculated about the cause of the phenomenon. Speculation and debate have, as you point out in your letter, resulted in the passage of House Bill 2510 which requires the University of Illinois to establish a department of general practice under the direction and supervision of a qualified general practitioner.

There are a number of factors relating to this action that I would like to call to your attention. The Bill, as enacted and signed by the Governor, did not provide for the funds necessary to create and operate a department. As soon as it was possible under the State of Illinois budgeting system, the University of Illinois College of Medicine requested funds to establish and operate a department of family practice. You may recall that there was a great deal of activity in the Legislature late in the regular 1970 legislative session about appropriations and budget matters. Eventually the University of Illinois budget was passed and approved by the Governor (August, 1970). That budget includes \$171,000 for a department of family practice—a reduction of \$171,000 from our original request. I know that you can understand that we could not begin recruiting until we were assured of funds to pay a department head and staff.

You will recall that the State Board of Higher Education requires that all new educational programs be approved by the Board. The educational program for a department of family practice was submitted to the Board of Higher Education in the fall of 1970. It has not yet been acted upon by that body and therefore we should not expend the funds that have been appropriated.

Despite these difficulties, we have an elective program in family practice. The Abraham Lincoln School of Medicine of the College of Medicine is actively searching for a department head. In addition, we plan to develop departments of family practice in the developing schools in Rockford and Peoria, and have budgeted funds for that purpose. We also expect to have departments of family practice in the group of metropolitan hospitals in the

Chicago area with whom we have recently affiliated.

So that I might personally become better informed about family practice, I created an advisory committee on family practice in the spring of 1970. We have met on several occasions and, I believe, have been working toward a better understanding of the educational problems relating to a department of family practice. The advisory committee has representation from the State Medical Society and the Illinois Academy of General Practice, as well as several faculty members from the College of Medicine.

One of the most difficult problems with respect to the development of a new department is the matter of space. At the present time we have no space available. We plan to house the new department head in temporary quarters. Eventually permanent space must be created.

The development of a new academic unit is a complex

and costly task. We believe we are moving steadily ahead and that great progress has been made.

If you believe it would be helpful, I would be glad to appear before the Board of Trustees of the Illinois State Medical Society to explain the several ways by which the University of Illinois is meeting the challenges for improving health care.

Sincerely yours

William J. Grove, M.D.

Executive Dean, Univ. of Ill. College of Medicine

*Ed. Note:* Information received from the Pritzker School of Medicine, University of Chicago, indicates that no separate department on family practice is contemplated.

## *Music - Dancing - Entertainment*

### *Combined Banquet*

Illinois State Medical Society  
University of Illinois Alumni Association  
Tuesday, May 18  
Arlington Park Towers

6:00 p.m. Reception for J. Ernest Breed, M.D., President  
Illinois State Medical Society  
and  
Armand Littman, M.D., President  
University of Illinois Alumni Association  
(Reception compliments of INTRAV, INC.)

7:00 p.m. Dinner (tables of 8 may be reserved until May 1.)

8:00 p.m. Presentation of Awards and Entertainment  
by the  
Incomparable Hildegard  
Dancing to follow  
\$15 per person  
*Reservations through ISMS Convention Manager  
or  
University of Illinois Alumni Association*



# economics and peer review

## COUNCIL ON ECONOMICS AND PEER REVIEW

The newly formed Council on Economics & Peer Review was active during the year in urging the establishment of county peer review committees throughout the state. Several requests were made to the 91 county medical societies, comprising the State Society, to appoint peer review mechanisms. The Council is pleased to announce that as of late March, 78 county societies have indicated their plans for doing peer review. Of this number, 69 have appointed committees. The other nine societies, because of limited membership, have indicated they will use the district peer review mechanism.

The above complies with Resolution 70 M-53.

A primary responsibility of the Council is to serve as the appellate peer review body for the state. The Council fulfilled this objective eight times during the year, considering cases that had initially been examined by local peer review committees.

Another important function of the Council is its educational responsibility to local peer review committees. Local committees must be kept current on all information that will prove beneficial in performing local peer review activities. This educational responsibility is being fulfilled by the Council through a periodic newsletter sent to all members of local and district peer review committees. This material is also being reproduced in the *Illinois Medical Journal*.

Resolution 70M-3, outlining the responsibilities of patients and third party carriers for paying physicians fees, was implemented by the Council. The Council's Advisory Committee to DVR spent considerable time requesting the Department to re-imburse physicians on a usual and customary fee basis. Similar requests were made by the Council to other insurance carriers through the Health Insurance Council.

Resolution 70M-39, asking that local peer review committees be paid for their activities when considering cases initiated by third party carriers, was also implemented by the Council. A letter was sent to the Health Insurance Council urging its member insurance carriers comply with the terms stated in this resolution.

The Council's Advisory Committee to the Division of Vocational Rehabilitation held two meetings during the year. Major issues considered included payment of usual and customary fees by DVR, and the utilization of DVR services.

On the first issue, the DVR Director agreed to increase fees to the levels presently paid by the largest state purchaser of physician services. DVR said this increase will reach the usual fees of at least 70% of the physicians in Illinois.

Regarding the eligibility of persons to receive DVR services, the Department agreed to instruct its Councilors to fill out requests for physicians' services completely. This will provide the physician with adequate information as to the reason for the examination.

A questionnaire prepared by the Committee, designed to learn local opinion on the DVR program, was sent to every county medical society. The answers to the questionnaire were to reflect the majority opinions of each county society. Thirty-five county medical societies returned questionnaires. This is more than one-third of the total county societies comprising ISMS. A compilation of questionnaire results follows:

	Yes	No
I. Do you consider DVR a worthwhile activity?	33	2
II. Do your members feel they are adequately reimbursed by DVR for providing medical care?	26	9
III. Do your members think the DVR program is being abused?	15	20
IV. Do your members feel that DVR eligibility guidelines are satisfactory?	20	15

Comments most frequently reported on the questionnaire included:

- Physicians complaining DVR Councilors are not supplying complete information on potential DVR recipients.
- DVR Councilors referring cases to physicians for seemingly minor reasons.
- Councilors use poor judgment in recommending students for DVR.
- DVR should clarify its eligibility guidelines.
- DVR should update its fee schedules.

This report is submitted for information only and no action is required by the reference committee.

Glen E. Tomlinson, *Chairman*

Fred A. Tworoger	Earl Walker
Charles E. Baldree, Jr.	R. Gregory Green
Eli Borkon	Robert Muchrcke
Stanley Bobowski	Hilliard M. Shair
Edward DuVivier	Reuben Gaines
John L. Eaton	Clinton L. Lindo
Maynard Shapiro	Robert Becker
John P. Marty	Burton Jacobson
Don Michels	

Fred Z. White, *Consultant*

Joseph R. O'Donnell, *Consultant*

Frank J. Jirka, Jr., *Consultant*

Joyce Root, *SAMA*

James Whitehouse, *SAMA*

### Advisory Committee to DVR

Eli Borkon, *Chairman*

Joseph Compton	Thaddeus S. Pierce
Thomas R. Glatter	Aaron M. Rosenthal
Harry Grant	Harold A. Sofield
Brian H. Huncke	A. Walter Wise

Gerald M. Berkowitz

Charles K. Wells, *Consultant*

Frank J. Jirka, Jr., *Consultant*

## ILLINOIS DEPARTMENT OF PUBLIC AID

Public Aid programs for fiscal year 1972 (July 1, 1971 through June 30, 1972) are best understood when viewed from the perspective of the past dozen years.

The 1960s opened on a rising trend as persons of low education and marginal work skills lost their jobs during and immediately following the economic recession of 1960 and 1961.

The uptrend was stemmed and then reversed beginning in 1962, and lasting through 1966. The strong declines in Illinois from mid-1962 through 1965, were especially noteworthy since national loads in the same period were climbing more than 10%. Then in mid-1967, Illinois' and national caseloads began an accelerating climb which has extended into 1971.

Illinois' monthly average of 735,254 recipients during 1970, was 290,190 persons, or 65.2% higher, than the monthly average of 445,064 during 1962—the previous peak year after World War II.

During the current uptrend (mid-1967 through 1970), the monthly average rolls increased by 211,500—a significant number being added in 1970. Average monthly expenditures were \$29.6 million in 1967, \$37.8 million in 1968, \$44.0 million in 1969, and \$57.9 million in 1970.

There are many observable factors which cumulatively have brought upward spiraling caseloads and costs. One major cause of poverty obviously is unemployment. The nation is experiencing, incongruously, both an economic recession and rampant inflation. Recession affects first those with marginal education and low job skills but lately there have been large scale layoffs in specific industries and many well educated, highly skilled persons have lost their jobs.

Inflation affects everyone, but persons with fixed incomes are hardest hit. Many older persons literally back into welfare as their income no longer is adequate to meet medical bills or basic living costs.

Two surveys in the 1960s—one in Chicago and one in E. St. Louis—revealed that 51% of the adults in the Aid to Dependent Children program could not read at the fifth grade level—and thus were termed "functional illiterates." The implications are clear—a very high proportion of recipients need training and education before they can fill jobs on a regular sustaining basis. Without it, they can fill only marginal jobs and then only seasonally.

### Education and Training

The emphasis on education and training which lowered the caseloads in the period 1962-1966 continues to have a dampening effect on the rises now taking place. HEW's most recent report of "Trends in AFDC" shows this. HEW reported 23 states, one territory, and Washington D.C. as experiencing AFDC increases in excess of 30 percent for the 12 months ending August 1970. Illinois' ADC increase in the same period was 24%.

Realistically, the majority of recipients—all programs—are either unemployable or have limited potential.

In December 1970, the latest month of complete record in Illinois, the aged numbered 67,600, the median age being about 78 years with many residing in nursing homes and other group facilities. The permanently and totally disabled totaled 58,000, and the blind, 1,950. Of the ADC rolls, 381,400 were children. Their potential depends on

remaining in school to acquire the basic tools of self-support. Some 9,200 families were headed by an unemployed father. The remaining 116,100 families were headed almost exclusively by mothers.

Illinois' training/employment emphasis is directed first toward fathers and then the ADC mothers, for it is the latter who comprise the largest group with potential for employment.

The Department of Labor's Work Incentive Program (WIN) has been slow getting underway but now is operating in nine Illinois counties with 5,000 training slots allocated through fiscal year 1971 (June 30, 1971). Currently, the education/training contractually purchased by IDPA through local public school districts leads in the number of trainees. Counting all sponsorships, 12,250 recipients were in training during December 1970. This is a slightly higher number than that of 1963, 1964, and 1965.

### State's Residency Requirement

There are many other factors which are contributing to rising caseloads. Poor education and low job skills, unemployment, general economic recession, and inflation have already been named. But there are other factors. The state's durational residency requirement of one year as one condition of eligibility was struck down by a federal court in February, 1968. From February, 1968, through December, 1970, some 13,500 cases (not counting local General Assistance in 1970) with residency of less than one year have been added to the rolls. The court's requirement that assistance not be terminated if an appeal or hearing is to be held prolongs the stay of many on the rolls. Deserting fathers and unwed parent-hood contribute significantly to the ADC rolls.

Major increases are also the result of greater information on public assistance programs through extensive news coverage and the activities of community action programs (many funded by OEO). Thousands of eligible individuals and families, who formerly refrained from applying for assistance, now do so without inhibition. Court decisions and decisions by federal welfare administrators are ever widening eligibility requirements and extending coverages. These make budgeting a very difficult endeavor, necessitating deficiency state appropriations.

It should however, be emphasized at this point that persons receive public assistance because they have been determined eligible to receive it in accordance with legislation and established standards. Their financial need developed from one or several factors extant in society and quite outside IDPA's control. IDPA can only draw on all available resources to rehabilitate the potentially employables to self-support and to improve on the comfort and self-care potential of those whose stay on the rolls is to be prolonged. These latter are the aged, the blind, the disabled, and children who are encouraged to stay in school and build a firm base for self-support as adults.

### Outlook for 1971

The immediate outlook for the remainder of fiscal 1971, is continuing rises in caseloads even if the economy starts to improve. A deficiency appropriation will be necessary.

The original budget for fiscal 1971 was \$789.2 million, composed of:



	In Millions Percent	
Medical Assistance .....	267.8	33.9
Aid to Dependent Children .....	314.8	39.9
Assistance to the Aged, Blind, or Disabled .....	97.7	12.4
General Assistance .....	94.8	12.0
Adult Training and Child Care .....	13.0	1.7
Miscellaneous Distributive expenses .....	1.1	0.1
	<hr/> \$789.2	<hr/> 100.0

As of this writing, IDPA's budget is not yet firm for fiscal 1972 (July 1, 1971 through June 30, 1972). However, it will be substantially higher, based on projections of caseload rises within the context of a flagging economy, and trying to anticipate legislative changes by the federal Congress, court decisions, and federal administrative changes.

### Miscellaneous

Several miscellaneous factors are of interest to medical practitioners. A series of articles in the *Illinois Medical Journal* in 1968-69, explained many facets of computerized payment of medical and drug vendor bills. A similar series of interest to dentists appeared in the *Illinois Dental Journal* in the latter months of 1970, and early 1971.

Physicians are better acquainted with the quality review system required by federal HEW regarding medical services and goods provided to public aid recipients. In Illinois, peer professionals act as consultants for IDPA in the review of the performance of physicians, podiatrists, optometrists and dentists.

The Food Stamp program was greatly liberalized on March 1, 1970. Purchasers began paying less and getting more stamps, and the broadening of the income/assets requirement made more nonassistance households eligible for the program. Participation has greatly increased, while food purchasing power increased 47%.

Improvements have been made in shifting aged patients from state mental hospitals to lesser care facilities and to communities through joint cooperative procedures of the Department of Mental Health, the Department of Public Health and IDPA.

In conclusion, December data just now available shows a total of 735,250 recipients. By program, the rounded numbers are:

	Grants Medical	
	Total & Medical	only
Aged	67,625	34,500
Blind	1,950	1,650
Disabled	58,075	45,200
Aid to Dependent Children	511,000	483,625
General Assistance	96,600	DNA
Totals	735,250	564,975
		73,675

NOTE: DNA—Does Not Apply

Harold O. Swank, *Deputy Director*

## ILLINOIS DIVISION OF VOCATIONAL REHABILITATION

While fiscal 1970, showed a decline from the previous year's all-time high in cases closed rehabilitated, significant shifts in service patterns and referral sources prom-

ise greater returns than ever before on tax dollars invested in vocational rehabilitation services.

The statistical record reveals: Increasing coordination of DVR's service efforts and resources with the service needs of other state agencies; increasing emphasis upon service to youths who otherwise might face lifetime dependency.

Statistics cannot convey the full and dramatic meaning of these simple facts: Mentally retarded youths—who just a few short years ago seemed doomed to lifetime dependency—now are becoming wage earners and taxpayers; Youths with behavior problems are being diverted from byways of destructive delinquency and criminality into the mainstream of social and economic productivity; School dropouts are receiving the special attention and training so vital to their future socio-economic self-sufficiency; and socially and culturally disadvantaged youths are receiving the special help they need to become employable and employed.

For many of these youths, vocational rehabilitation has been the safety belt halting the headlong plunge toward disastrous dependency. For the taxpayers whose funds are invested, gains must be measured both in reductions in the costs and losses accruing to unnecessary and unwanted dependency and in the human and dollar values realized through increased social and economic productivity.

### Highlights of Helping People

(During fiscal year ending June 30, 1970)

4th Illinois Ranks 4th in the Nation in number of persons rehabilitated.
12,079 People Rehabilitated
30,749 Persons remain at some level of service at end of fiscal year
42,613 Cases screened by Illinois Federal Disability Program for referral to Vocational Rehabilitation Counselors during fiscal year
62,631 People referred for service
\$832,176 Projected annual reduction in public aid payments at time of closure
\$1,411,897 Federal grants for rehabilitation of Illinois people
\$26,854,828 Increased earnings for the year on the 12,079 rehabilitated
\$42,119,376 Total earnings for the year of the 12,079 rehabilitated
\$98,000,000 Added to Illinois economy through disability beneficiary payments to Illinois residents each year

### Purchased Services for 12,079 people rehabilitated

Diagnostic	\$1,138,896	Training	\$3,227,169
Surgery	\$ 287,791	Maintenance	\$1,378,557
Treatment	\$1,137,921	Transportation	\$ 183,692
Appliance	\$ 369,822	Tools and	
Hospitalization	\$ 806,237	Other	\$ 65,243

### TOTAL

All Services \$8,595,328

To be eligible for these services, the applicant must have a disability which prevents him from earning a living, or prevents his getting a job more suited to him, or threatens his continued employment; have a reasonable chance of being able to work in suitable employment after services are provided; both men and women are eligible, and a means test is required for all services ex-

cept diagnostic, counseling and guidance, training, and placement.

**Illinois Federal Disability Program  
Fifth Largest in the Nation**

**The Figures:**

Disability Claims on hand July 1, 1969	2,785
Disability Claims received during fiscal year, including June 30, 1970	44,831
Disability Claims on hand June 30, 1970	3,515
Number of disability beneficiaries in payment status in Illinois 1969-1970	91,004
Cases screened for referral to Vocational Rehabilitation Counselors during fiscal year ending June 30, 1970	42,613
Percentage of Social Security Administration cases referred to Vocational Rehabilitation	30.5%
Total amount per annum paid disability beneficiaries in Illinois now approaches	\$98,000,000

**The Facts:**

Approximately 60% of the claims for Social Security disability benefits are allowed and 40% are denied. Statistics show that one-third of those denied seek reconsideration of the decision and if the claim is still denied, 50% of those will appeal. The fact that the average amount paid on a Social Security disability claim is \$20,000 causes a number of claimants to prosecute their claims to the U.S. Courts each year.

The Illinois Federal Disability Program is the fifth largest agency in the nation engaged in disability determi-

nation for the Social Security Administration. Only California, New York, Pennsylvania and Texas have larger work loads and staffing.

During the fiscal year just ended, the disability unit, through the parent agency, signed another agreement with the Social Security Administration. This provides for the disability unit to assist in the development of medical evidence of miners' and widows' claims under the Black Lung provisions of the Federal Coal Mine Health and Safety Act of 1969.

With the cooperation of the Bureau of the Budget and other state agencies, DVR has initiated a series of cost-effectiveness studies of all aspects of its utilization of service personnel and service funds.

The accelerating involvement of service personnel and increasing investment of funds in services to youth will be important parts of these cost-effectiveness studies. Below is part of this summary report.

The past is prologue. The resources and resourcefulness of the present—if promptly and properly identified and effectively coordinated—will mould the shape of a future in which unnecessary and unwanted dependency, with all of its costly consequences, will gradually lessen. Our investments in the youth of today who need special help to avoid or overcome dependency is an investment in this kind of future.

To the Governor, the members of the General Assembly, and the host of others whose cooperation is implicit in these summary reports of progress, I offer heartfelt gratitude.

Alfred Slicer, *Director*

**FISCAL YEAR 1970**

Investment in Purchased Services distributed by	All Cases Closed During Period				All Cases Open on Books At End of Period					
	Purchased Service				Purchased Service					
	CASES		Expenditures		CASES		Expenditures		Unliquidated Authorizations	
Major Disability Groupings	Number	%	\$ Amount	%	Number	%	\$ Amount	%	\$ Amount	%
GRAND TOTALS	31,882	100.0	9,707,879	100.0	30,749	100.0	16,974,602	100.0	2,111,551	100.0
Blind and Visually Handicapped	1,944	6.1	665,651	6.9	2,840	9.2	2,075,714	12.2	220,638	10.4
Deaf and Aurally Handicapped	1,380	4.3	645,632	6.7	1,746	5.7	1,203,299	7.1	88,299	4.2
Orthopedic Deformities	6,851	21.5	1,880,483	19.4	6,380	20.7	4,510,257	26.6	575,145	27.2
Amputees	793	2.5	344,539	3.5	776	2.5	458,943	2.7	77,785	3.7
Mental Disorders (inc. Behavioral)	7,233	22.7	2,159,713	22.2	6,280	20.4	3,028,269	17.8	397,108	18.8
Mental Retardation	2,455	7.7	1,425,271	14.7	4,076	13.3	2,274,515	13.4	157,683	7.5
Epilepsy	677	2.1	199,224	2.1	684	2.2	358,167	2.1	44,757	2.1
Cardiac and Respiratory	3,275	10.3	450,540	4.6	1,597	5.2	716,790	4.2	119,700	5.7
Dental	2,633	8.3	756,528	7.8	2,729	8.9	449,328	2.6	166,166	7.9
ALL OTHER DISABILITIES	4,461	14.6	1,180,298	12.2	3,641	11.8	1,899,320	11.2	264,270	12.5



Cases Open on Books, Start of Fiscal 1971  
Distributed by Age at Referral

	TOTALS	
	Number	%
GRAND TOTAL	30,749	100.0
UNDER 18	8,575	27.9
18-to-20 inclusive	5,378	17.5
21-to-24 inclusive	3,141	10.2
25-to-29 inclusive	2,676	8.7
30-to-34 inclusive	2,005	6.5
35-to-39 inclusive	1,872	6.1
40-to-44 inclusive	1,783	5.8
45-to-49 inclusive	1,801	5.9
50-to-54 inclusive	1,507	4.9
55-to-59 inclusive	1,202	3.9
60-to-64 inclusive	516	1.7
65-and-over	293	1.0

"... vocational rehabilitation services can have positively discernible effects for a long time, even forty or more years."

(See below)

The following is excerpted from "An Exploratory Cost-Benefits Analysis of Vocational Rehabilitation," published in 1968 by U.S. Department of Health, Education and Welfare, Vocational Rehabilitation Administration, Division of Statistics and Studies, Washington, D.C. 20201:

"b. The number of years of earnings

The assumed retirement age for persons in the first four age groups (as shown below) was 62. For the age group 55 to 64 years old, 65 was the assumed retirement age while for clients 65 years old and over, it was 70.

Arguments for higher and lower assumed retirement age both seem reasonable. One can argue, for example, that disabled persons are more likely to weary of work through the years and will, therefore, retire sooner than non-disabled persons. On the other hand, rehabilitated workers tend to be in the lower economic strata of society and would likely feel compelled to earn as much money as possible for as long as they can. *Whatever the retirement age, a crucial underlying assumption in the computation of earnings until retirement is that vocational rehabilitation services can have positively discernible effects for a long time, even forty or more years (italics added).*

The average length of time to rehabilitate a client once he is accepted for services is about one year. Subtracting the median age of each age group plus one year from the assumed retirement ages yielded the number of future years for which wages might be earned. These were:

Age group	Years of earnings	Age group	Years of earnings
Under 20	43	45-to-54	11
20-to-34	34	55-to-64	4
35-to-44	21	65-and-over	2

(end of excerpt)

SUBCOMMITTEE ON DRUGS  
AND THERAPEUTICS

The Sub-Committee on Drugs and Therapeutics met several times during the past year to refine the drug list contained in the Drug Manual of the Illinois Department of Public Aid.

Countless hours were spent in reviewing physicians' requests for drugs not listed in the manual. A complete and accurate record of requests and committee actions are kept in the Society's office.

In 1970, the committee received 3,013 written requests for drug usage. The Committee also reviewed numerous requests from pharmaceutical companies and has taken action at their request.

The Committee discussed at great length the prescribing habits of physicians, and concurred that additions and deletions to the Drug Manual should be based on the following criteria: (1) greater efficacy of drugs; (2) increased clinical safety regarding drug reactions, interaction, and toxicity; (3) physicians' prescribing habits; and (4) relative cost in relation to equally effective agents.

*Clin-Alert*, *PMA Newsletter*, and other information currently available on drug reactions, have been channeled to the Committee at regular intervals. The Committee never hesitated to seek expertise opinions when additional experiences would prove helpful.

In October, the members participated in a telephone conference with members of the Pharmacy Board and officials of the Illinois Pharmaceutical Association relative to the movement to remove anti-substitution restriction on pharmacists.

In accordance with the directives of the Committee on Drugs and Therapeutics, Louis Gdalmán, R.Ph., our consultant, and Mr. A. Kircher, of the IDPA, have reviewed the Manual in its entirety. It has been completely edited and all needed and approved changes have been incorporated. This includes addition of new products, revision

and standardization of maximum quantities, regrouping of same products under U.S. adopted title, and revisions approved by the ISMS Committee on Drugs and Therapeutics at its January, 1971, meeting. The latter includes the following: Amphetamine Sulfate U.S.P. (Benzedrine Sulfate) #9022, and dextro-Amphetamine Sulfate U.S.P. (Dexedrine) #9112 are eliminated from the Drug Manual. A physician who desires to prescribe the above mentioned drugs for patients ill with narcolepsy or patients with cyclic (metabolic) edema, may direct a written request to the Drugs and Therapeutics Committee, ISMS, 360 N. Michigan Avenue, Chicago, 60601, setting forth the medical facts in the case and the case name and the address of the recipient. This will be handled in the same manner as any drug requiring special approval for use, by the Drug and Therapeutic Committee (#9998).

Drug products which are still in the Manual that no longer have FDA's approval will be deleted. Space does not permit listing these medications in this report. The complete 1971 edition of the Drug Manual of the IDPA is being finalized for publication.

The committee appreciates the cooperation it has received from the physicians as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the IDPA for future revisions of the Drug Manual.

This is a report of information and no action is required by the reference committee.

Robert C. Muehrcke, *Chairman*

Joseph D. Cece

Richard L. Landau

Charles R. Frazer, Jr.

W. H. Walton

*Consultants*

Louis Gdalmán, R.Ph.

Henry A. Holle

A. E. Livingston



# education and manpower

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## COUNCIL ON EDUCATION AND MANPOWER

The Council on Education and Manpower, with its constituent committees, has been engaged in the continuous analysis and review of items and activities of paramount importance in the fields of Medical Education, Continuing Education, and Allied Health Education. In addition, activities of the Advisory Committee to SAMA, the Student Loan Fund Committee, and the Scientific Assembly Committee have been reported to this Council.

The field of education, especially medical education, is undoubtedly the principal concern of today. There are many who are crying for shortened curriculums, increased manpower and better health care delivery. The purpose and aim of this Council and its Committees is to find ways to meet these needs while guaranteeing quality education and quality medical care.

We have been most encouraged by the spirit of co-operation evidenced by the officers and trustees of the Illinois State Medical Society as well as the representatives of the seven medical schools in Illinois. These latter individuals have contributed much to the deliberations of the Council. We are indebted to them for their activity.

Several primary activities of the Council are reported to the House of Delegates. The State-wide Council on Continuing Medical Education, first proposed by President Cannady during his term of office, and continued by President Breed, has been taking shape. Several members of the Committee on Continuing Medical Education and the Council on Education and Manpower have assisted in the deliberations establishing this. Actual structuring of the Council will be reported elsewhere. However, the Council on Education and Manpower commends to the House of Delegates the activities in this field and the proposed state-wide Council.

Also recommended to the House of Delegates are the refresher courses, which were planned with a great deal of innovation for this convention, by the Committee on Scientific Assembly. All members of the House of Delegates are encouraged to participate in these, as well as the self examination booth set up in the scientific exhibit area. Our Convention Chairman and Director of Exhibits should be recognized for their signal efforts in these matters.

As authorized at the 1970 annual convention, the representatives from the Student American Medical Association (SAMA) have been allocated one delegate and one alternate in the House of Delegates. We welcome these individuals to our midst for the first time in 1971.

### SCIENTIFIC ASSEMBLY

The Committee on Scientific Assembly is grateful to

the Board of Trustees for providing a new setting for the 1971 Annual Meeting of the Society. The Committee is enthusiastic about the facilities at the Arlington Park Towers and has tried to design an attractive educational-scientific program so that ISMS members and their wives will be encouraged to attend the 1971 convention in greater numbers than ever before.

There are two new features at this year's meeting—as well as a couple of block-busting general sessions—that the Committee hopes will be popular among members. Some 36 instructional courses—12 each of the three mornings of the convention—are being presented this year for the first time, and a medical self-testing complex being provided jointly by the ISMS Foundation, Regional Medical Program, and the University of Illinois Center for Educational Development.

The Committee looks forward to implementation of the proposed merger of the ISMS annual convention and the Chicago Medical Society's annual clinical conference, and its cooperation is offered.

### STUDENT LOAN FUND

The Student Loan Fund Committee is in the process of making a carefully controlled statistical analysis of our program over the years, with special reference to the retention of physicians in the state. Because of the shortage of student loans, we have had unprecedented numbers of applicants and it has reached the point that the fund will have to be increased if we are to meet the demand. It is felt that before we do this we should have some reliable data to confirm the effectiveness of this approach. Questions about the future of our program have been raised in our discussions with officials of the University of Illinois, who doubt the long-range value of the program and want to eliminate the quota. They propose a citizens' advisory committee to the Committee on Admissions, on which we would be represented. The Committee would help screen and weigh the applications of students coming from areas that are short of physicians.

There were a large number of applicants for our program this year and we were able to recommend 20 students to the University of Illinois for admission based on careful evaluation of their suitability and motivation for rural practice. Of these, 13 were definitely accepted, two conditionally, and five denied. The University's acceptance was based on the admission committee's judgment as to the scholastic viability of the applicant. A close study of the present loan commitment makes it apparent that there is not enough money to give all of these students loans. If we are to follow the recommendations of the legislature and the House of Dele-



gates, and are successful in increasing the number of qualified applicants to 20 per year, the fund will have to be enlarged. The representatives of the Illinois Agricultural Association feel that their organization would be willing to do this if our studies show that the program is accomplishing its goal.

The above mentioned statistical study will be done with the cooperation of Dr. Dale Mattson, of the University of Illinois, the Chairman of the Student Loan Fund Committee, and Mr. Roy Will, Executive Secretary of the Illinois Agricultural Association. It is hoped that this study will give us reliable data on which to either expand our program or move in another direction.

A recommendation from the 1970 Reference Committee, indicating that the Student Loan Fund Committee should work with the University of Illinois to develop admission policies and tutorial services giving consideration to border-line scholars from medically deprived rural areas, was considered by the Student Loan Committee and the Council on Education and Manpower. It must be pointed out that tutorial services already are available to all students, and that the Medical Opportunities Program, funded by the Office of Economic Opportunity, also is in effect in this area. The government program has expanded these inner city student programs. Until a final analysis and assessment of newly instituted governmental programs is available, no decision in this matter can be made by the Student Loan Fund Committee.

Presently participating in activities, sponsored by the Student Loan Fund, are 37 medical students. This is a very large number and has created something of an economic drain on available funds. The Council has instructed the Student Loan Fund Committee to explore possible alternatives to gaining financing for medical students, as well as other concerns, in gathering funds for this activity.

With respect to support for the Council on Bio-Medical Careers, which in 1970 was suggested to be \$10,000, allocated from the Task Force on Physician Shortage, it was the sense of the Council that the State Medical Society is already involved in many activities similar to those of the Council on Bio-Medical Careers. In fact, the Health Careers Council of Illinois receives one of the largest stipends from the dues dollar of the Illinois State Medical Society. Therefore, the Council indicated that it would support the activities and lend encouragement to the Council on Bio-Medical Careers. Financial support was referred to the Task Force on Physician Shortage and Services to Medically Deprived Areas.

A resolution in 1970, recommending a loan program for inner city students, to be funded by \$50,000 from ISMS and a like amount from other agencies, was referred to the Task Force on Physician Shortage and Services to Medically Deprived Areas. The Task Force considered this matter and will report on it separately.

Since Doctors of Osteopathy presently complete the same requirements as Doctors of Medicine, to practice medicine and surgery in all of its branches in Illinois, osteopathic students in accredited schools of osteopathic medicine were approved for inclusion in the student loan fund.

#### Medical Practice Act

The Council on Education and Manpower met in September with representatives of the Medical Examining Committee of the Illinois Department of Registration and Education, as well as representatives of the Department

itself. The purpose of the meeting was to discuss the medical practice act with relation to medical school curriculum. The following statement was adopted and subsequently recommended and approved by the Board of Trustees:

*Recognizing that admission of students to medical school, in advance standing, may be an important way of increasing the number of students enrolled and physicians graduated from Illinois medical schools, the Council on Education and Manpower requests that steps be taken to facilitate the process. Specifically urged is appropriate amendment legislation to the Medical Practice Act to exempt from the time requirements for medical school attendance such students as are admitted by the faculty of the school to advance standing.*

Advance standing could be achieved by attendance at an approved medical school outside of Illinois or by completion of course work from the medical school while still an undergraduate. The Medical Practice Act presently allows the completion of medical school in 132 weeks of study and not less than 35 months. Amending legislation would remove the time element. *The Council recommends that the House of Delegates also approve this Concept.*

#### SAMA

The Advisory Committee to the Student American Medical Association has been primarily concerned with the operation and evaluation of the Medical Education-Community Orientation (MECO) project. The second season was completed for 140 students in 54 Illinois hospitals and the Board of Trustees approved the project for a third year.

In January, a conference was conducted for students and hospital officials to obtain an evaluation of the first two years and determine what changes might be desired for 1971. The chief recommendation was for post-matching orientation, i.e., a provision for participating students to meet officials of the hospital where they are to be assigned before they report for duty. Plans for such orientation are underway.

During the year, the Advisory Committee to SAMA requested the Illinois delegation to the AMA to introduce a resolution asking the AMA House of Delegates to direct its Council on Medical Education to study the SAMA-MECO project, and consider recommending it to medical schools for elective academic credit. The AMA delegation accomplished this and it was approved by the AMA House of Delegates.

Paradoxically, going national has created some problems, in determining which operational responsibilities and financial obligations belong to the national SAMA office and which should be reserved for the states. MECO, in Illinois, finds itself being expected to contribute to a national program from which it needs little in the way of service. The Advisory Committee has taken the position that its primary responsibility is to strengthen MECO-Illinois, and that if the national SAMA office has need of state support, it should develop a realistic budget and request specific, pro-rata amounts from the states.

#### Education

Physicians' Assistants became a very topical item in late 1970, and early 1971. The Committee on Allied Health Education continued to consider this particular facet of the delivery of health care and maintained awareness of the demand for establishment of this new category of personnel. It was agreed that this could conceivably ease some of the manpower shortage. This problem



is not resolved. As of the writing of this report, legislation pending in the Illinois legislature may ease some of the concern. A bill introduced by Rep. Coulson, which allowed certification of P.A.s, was heard in the 77th General Assembly. Testimony in favor of the bill was provided by ISMS representatives, who indicated that the bill was acceptable in principle, but certain reservations remained—physicians' assistants would be allowed only to clinically practicing physicians; only two assistants would be allowed any physician; and vertical and horizontal mobility must be ensured for the person being qualified as a physician assistant.

Another activity with which the Council on Education and Manpower is wrestling is the problem of licensure, and what education is necessary for licensure. This is also a concern of the Medical Legal Council with its Committee on Licensure, as well as other groups within ISMS. The Council on Education and Manpower would recommend support for activities leading to national licensure and acknowledgement of training of the ECFMG which will allow advance standing leading to achievement of licensure.

A new Central States Council of Pre-Medical Advisors has been organized. The purpose of this group is to shepherd undergraduate medical students to weed out weak students, so that at the end of pre-med training there are not so many weak students applying for medical school. These large numbers have to be turned down and add to the tremendous number of applicants being processed through medical school admission offices. This might also salvage some of the so-called mediocre students for allied health professions. The Council will continue to work with this group and formulate essential programs to develop additional health manpower.

A concern of the Council and its Committee on Continuing Medical Education are recent activities leading to requirements for Continuing Medical Education. The Committee on Continuing Medical Education will meet to consider this subsequent to the publication of this report and will submit a supplemental report to the House on this matter.

Your chairman takes this opportunity to thank all the members of his Committee for their dedicated work and support during the past year. He also commends the chairmen of the various Committees for their effort in making Illinois medicine exemplary.

### **Disposition of AMA-ERF Funds**

Dear Dr. Scrivner:

The 1969, funds were used to purchase an electron microscope for one of our new faculty members, Dr. Karl Heinz Kohler, assistant professor of Pathology, who joined us last July. His special research is in the areas of amino acids and immunochemistry. In addition to his research, he is an effective teacher of medical students and graduate students, and is deeply involved in the new cell biology segment of the revised Medical School curriculum. An electron microscope was essential for Dr. Kohler's work. The AMA-ERF funds provided partial funding for this expensive equipment.

We are most grateful for your support this year as well as for past AMA-ERF contributions.

Sincerely,  
Leon O. Jacobson, M.D.  
Dean, *Pritzker School of Medicine*

Dear Dr. Scrivner:

On April 1, 1970, we received \$18,071.46 as our share of these earmarked allocations.

We have consistently relied on these monies to fill the ever-increasing realistic demands of supplement and salary increases for our full-time faculty. As in the past, these funds have been allocated to five, full-time clinical instructors in medicine, surgery and pediatrics, in the amounts of \$3-5,000 per teacher. The modest remainder has primarily been used to purchase various teaching equipment so vitally needed in modern programs.

On behalf of this institution, I want to express our thanks to all of you for this assistance. Our hope is that it will continue and expand, so as to keep pace with both the quality and quantity of medical manpower that our society is expecting.

Sincerely,  
LeRoy P. Levitt, M.D.  
Dean, *Chicago Medical School*

Dear Dr. Scrivner:

The funds were used to support tutors for the Medical Opportunities Program (disadvantaged students), workshops in the development of examinations for the evaluation of medical students, direct support of the community health center known as The Valley (a setting for outpatient learning for medical students), to support a consultant in public health prior to the establishment of the School of Public Health, partial salary of two different faculty members, production of teaching film, support of recruitment for the new Schools in the College of Medicine, that is Urbana and Peoria.

I hope this listing is specific enough for the purposes that you have in mind. Needless to say, the AMA-ERF funds are of great value to this College of Medicine as it undertakes to more than double its enrollment as quickly as possible.

Sincerely yours,  
William J. Grove, M.D.  
Executive Dean, *Univ. of Illinois, College of Medicine*

Dear Dr. Scrivner:

As in the past, the AMA-ERF funds have been used to support faculty salaries in the Medical School for the current year. When AMA-ERF funds first became available, they enabled the Medical School to correct some inequities in the salary structure. Research and training funded by block grants came along to sustain the trends started with AMA-ERF support.

Now with the cutback of federal funds, your support is needed more than ever before. We do hope that these unrestricted funds will continue to come to us to help fill the ever increasing need for private universities affiliated medical schools.

The specific purpose to which your funds have been utilized in the past year has been to help us begin a truly academic department of orthopedic surgery. In the past, this department has been chaired by an individual who had to make a major proportion of his income in the private practice of medicine. He, therefore, had relatively little time to spend in academic pursuits. This year, we have been fortunate to secure the services of a new chairman of orthopedic surgery who will spend the major proportion of his time in teaching and directing



research, with a minor proportion relegated to the care of private patients. Some of your funds have been used to increase the stipend we previously had available for a chairman's salary, and the remainder utilized to help support an additional orthopedic surgeon so he can spend a portion of his time with residents and students and on other academic pursuits. Without your funds, we would have had great difficulty in getting this department re-oriented.

At the moment, I am going through the agony of listening to each departmental chairman describe the needs for the coming year. We are counting on the continued support from the AMA-ERF funds to meet some of these needs.

On behalf of Northwestern University, I would like to express to you our deep appreciation for what you have done and are doing.

Sincerely,  
James E. Eckenhoff, M.D.  
Dean, Northwestern University Medical School

Dear Dr. Scrivner:

AMA-ERF funds contributed for members of the Illinois State Medical Society were used to supplement the salaries of six faculty members with the rank of Assistant Professor or above in the following departments:

- Department of Biochemistry
- Department of Microbiology
- Department of Pharmacology
- Department of Pediatrics
- Department of Medicine
- Department of Surgery

Sincerely,  
Paul Gazerro, Jr.  
Assistant Vice President—Finance  
Stritch School of Medicine

**Council on Education and Manpower**

Jack Gibbs, *Chairman*

- |                                    |                                  |
|------------------------------------|----------------------------------|
| T. Howard Clarke                   | Herschel Browns                  |
| Robert T. Fox                      | George O. Dohrmann               |
| Richard Magraw                     | Lawrence L. Hirsch               |
| R. Charles Oldfield                | Herman J. Nebel                  |
| L. T. Fruin, <i>Consultant</i>     | Donald Stehr                     |
| William M. Lees, <i>Consultant</i> | Fred Z. White, <i>Consultant</i> |
| William B. Rich                    | James Shaffer                    |
| Stritch School of Medicine         | Chicago Medical School           |
| John Graettinger                   | Edward S. Petersen               |
| Rush Medical School                | Northwestern Medical School      |

- |                             |                             |
|-----------------------------|-----------------------------|
| Richard H. Moy              | Richard Landau              |
| So. Illinois Medical School | Pritzker School of Medicine |
| Michael Youssi, <i>SAMA</i> | John Logan, <i>SAMA</i>     |

**Committee on Allied Health**

Richard Magraw, *Chairman*

- |                            |                      |
|----------------------------|----------------------|
| James D. Eggers, Jr.       | Burton M. Krimmer    |
| Robert B. Lynn             | Donald E. Rager      |
| Paul G. Theobald           | Sheldon Waldstein    |
| Kevin Paulsen, <i>SAMA</i> | Lawrence L. Hirsch   |
| <i>Consultants</i>         |                      |
| Mr. Donald C. Frey         | Walter C. Bornemeier |
| Eugene P. Johnson          | James B. Hartney     |
| Israel Light               |                      |

**Committee on Continuing Education**

Herschel L. Browns, *Chairman*

- |                            |                         |
|----------------------------|-------------------------|
| Kenneth W. Anderson        | Dear R. Bordeaux        |
| Robert E. Fitzgerald       | James A. Felts          |
| William F. Hubble          | Leo R. Green            |
| John C. Rathe              | Mays C. Maxwell         |
| Robert J. Shafer           | Forrest H. Riordan, III |
| Gordon H. Sprague          | Herbert Sohn            |
| Kong Meng Tan, <i>SAMA</i> |                         |
| <i>Consultants</i>         |                         |
| Fred Z. White              | George Shropshire       |

**Committee on Student Loan Fund**

Donald Stehr, *Chairman*

- |                                    |                                |
|------------------------------------|--------------------------------|
| Charles Salesman                   | Jack Gibbs                     |
| Jacob E. Reisch, <i>Consultant</i> | L. T. Fruin, <i>Consultant</i> |

**Advisory Committee to SAMA**

T. Howard Clarke, *Chairman*

- |  |                                   |
|--|-----------------------------------|
| N. Kenneth Furlong                           | Allison Burdick, Jr.              |
| Courtney P. Jones                            | Nathan Iglitzen                   |
| Clarence Walton                              | Louis Limarzi                     |
| Ronald Ban, <i>SAMA</i>                      | Donald Batts, <i>SAMA</i>         |
| Eugene Saltzberg, <i>SAMA</i>                | Mrs. G. F. Tufo, <i>Auxiliary</i> |
| <i>Delegate to ISMS House of Delegates:</i>  |                                   |
| Michael Youssi, <i>SAMA</i>                  |                                   |
| <i>Alternate to ISMS House of Delegates:</i> |                                   |
| David Shapiro, <i>SAMA</i>                   |                                   |

**Committee on Scientific Assembly**

Robert T. Fox, *Chairman*

- |                                |  |
|--------------------------------|--|
| Roger Hoekstra                 | J. Robert Thomson, <i>Director of Exhibits</i> |
| Elizabeth A. McGrew            | Laurel E. Keith                                |
| Gerald V. Stanton, <i>SAMA</i> | Donald L. Unger                                |
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# environmental and community health

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## COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

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The Council on Environmental and Community Health is concerned with maintaining a healthful situation for the residents of Illinois, and with recommending policies by which medicine can play a role in maintaining the public health. Pollution, occupational health, maternal mortality, welfare, and physical examinations, all fall within the purview of this Council and its Committees.

Within the Council are the Child Health Committee, the Maternal Welfare Committee, the Nutrition Committee, Public Safety Committee and the Radiation Protection Committee. Each of these Committees meets and discusses important items which are then reported through the Council to the Board of Trustees for the House of Delegates. Incorporated in this report are the actions of the Council and its constituent units.

We are indebted to the many groups, agencies, and individuals for help collecting information for the work of this Council and keeping us informed of ongoing activities in the field of environmental and community health. In particular we would like to thank the Illinois Department of Public Health, the Illinois Department of Mental Health, the Environmental Protection Agency, the Illinois Department of Public Aid, the Illinois Nutrition Committee, and the many voluntary agencies which have been most helpful.

### NUTRITION

The Nutrition Committee has been most active during the past year and has devoted much time to consideration of activities benefitting the public in the field of nutrition. This is through co-sponsorship of meetings as well as in formulating specific statements of policy.

The Committee again co-sponsored the Conference on Nutrition and Medicine with the Illinois Nutrition Committee. The meeting was held at DeKalb, October 2, 1970, in cooperation with the Nutrition Department of Northern Illinois University. The attendance was good and the program was outstanding. Excerpts from the Conference will be published in the *IMJ*.

Two meetings during the year were devoted to the problem of iron deficiency. In addition to the Committee, consultation and communications were received from Dr. Robert Mendelsohn, Department of Pediatrics and Community Medicine at the University of Illinois; Dr. Phillip Lankowsky, Department of Pediatrics, New York University School of Medicine; and Mr. Clifford Daly of the Penwalt Corporation. The Committee considered the question of iron deficiency and the prophylactic use of iron-fortified foods at great length. The following evolved from discussion and contributions of members and consultants.

1. Every effort should be made to improve the total food supply reaching the population, especially those in poverty income groups.
2. In addition, efforts should be made at the prevention of iron deficiency because of the frequency of iron deficiency in the population as a whole. It is to be recognized that iron deficiency is frequently only a marker for more comprehensive nutritional deficiency.
3. Infants, children and women in the child-bearing age group would be the groups most vulnerable to iron deficiency in the population.
4. Education in nutrition should emphasize the need for iron-containing foods in the diet. Insofar as inadequate iron intake is a frequent feature of diets in all income groups, but more especially the low-income categories, the prophylactic supplementation of food staples, such as milk and bread, would seem appropriate.
5. The most common cause of iron deficiency in infancy is inadequate dietary intake of iron, especially when this is superimposed on inadequate iron stores resulting from premature birth, twins, or inadequate material iron intake during pregnancy. For those infants who are to receive cows' milk formulas, the use of a heat-modified iron-fortified product would be preferable to homogenized unfortified milk during the first six months, and possibly throughout the first year of life. Such a product should be made available at a cost comparable to homogenized whole milk and should be available to those in welfare categories through special purchase, if necessary.
6. It is to be recognized that there are inherent risks involved in the ingestion of cows' milk products during infancy. Anemia may be caused by milk-induced enteric blood loss, and lactose intolerance is common in certain ethnic groups. Breast feeding avoids many of the problems associated with cows' milk ingestion and should be promoted as the feeding of choice.
7. Industry spokesmen described a trend toward the use of iron-enriched flour in the preparation of bread and certain snack foods made from flour. There are problems related to the taste-acceptance of foods made from enriched flour. This apparently relates to the catalization of the rancidification of fats caused by ferrous salts. Iron-fortified bakery products should be recommended for those in high-need categories who are unable or unwilling to use other iron containing foods.

*Endorsement of these statements is requested of the House.*



The Committee will co-sponsor a meeting in March, 1972, with the Illinois Food Technologists and the Chicago Nutrition Association. This meeting will address itself to Nutrition and Consumerism, and the impact on food supply of the educational, legislative, and medical influences. A committee was appointed to plan the program.

The Committee recommends that there be statewide coordination of the various organizations and social-service agencies involved in nutrition and that particular effort be made to expand nutrition counselling for welfare recipients through the Department of Public Health.

### **MATERNAL WELFARE**

The Maternal Welfare Committee has met regularly during the past year. During this period it has been very active in analyzing data regarding maternal deaths as well as morbidity.

The Committee will continue to analyze maternal deaths as they occur and to serve as the advisory group to the Illinois Department of Public Health, as well as the Medical Society, on matters which relate to Maternal Welfare. It has submitted, to Dr. Van Dellen, a series of case reports derived from protocols from prior years which will be of help in bringing to the attention of the doctors of Illinois those areas which seem to be most troublesome in the production of maternal mortality and morbidity. In addition to that, the chairman has cooperated with the Department of Public Health in setting up a new system for the investigation of maternal deaths and the preparation of the abstracts of these deaths.

Recent activities in the matter of abortion and laws relating to abortion in Illinois have been of serious concern to the Maternal Welfare Committee. It will maintain acute awareness of this.

### **CHILD HEALTH**

Resolution 70M-9, of the last session of the House of Delegates, related to school examinations for children entering school the first time in Illinois or at first, fifth, and ninth grade levels. The resolution provided that physicals may be done within one month of the child's birthday commensurate with the corresponding grade level. The Child Health Committee felt that further flexibility would be needed in the health examination regulations. It recommended to the Board of Trustees that such physical examinations be valid within six months of the child's birthday or during the year following the birthday commensurate with the year in school. This matter was referred to the Council on Legislation and Public Affairs, and Legal Council for implementation, and is under development.

Support for Comprehensive Health Education Legislation, developed by the Office of Public Instruction, was given through the Board of Trustees.

The Committee also gave support through the Council on Environmental and Community Health for a pilot study of the requirements for physical examinations given to children under the supervision of the Illinois Department of Children and Family Services. Present regulations require such examination every two years. However, under the school code, examinations are required only every four years. In addition, to require a physical examination every two years, to the exclusion of having the examination more often when necessary, is

poor medicine. Therefore, the Child Health Committee recommended that Dr. Mack be allowed latitude, since full compliance with the law at present is impossible. Dr. Mack should study the effect of what is feasible in the way of periodic examinations and on the basis of this, report to the Child Health Committee as to what should be recommended to the Legislature.

It has been discovered that there are approximately 500 cases per year when it is necessary to get a court order to provide children with emergency care because parents are unwilling, unable or unavailable to give consent. In Cook County, a juvenile judge will come to the hospital or receive a hospital administrative officer any time of the day or night to sign papers authorizing treatment of children. The Committee feels that this should be done on a state-wide basis. Therefore, it did recommend, and the Board of Trustees approved, that juvenile justices be made available 24 hours each day for consultation with hospitals and doctors, to declare particular children wards of the court in order that proper medical or surgical measures may be taken to restore health or preserve life. This concern was forwarded to the Commission on Children.

High risk infant centers are an important concern to the Child Health Committee. During the next meetings of this Committee this will be a subject for in-depth discussion, for possible recommendation.

### **PUBLIC SAFETY**

A very active year was held by the Public Safety Committee. It met four times in eight months. One of its accomplishments was the editing and distribution of a revised disaster manual for hospitals. The original disaster manual had been published over three years ago. Repeated inquiries and requests depleted the supply and at the time a revision was being drawn up, some 300 requests for additional copies were pending. Distribution of the revised manual was in April, 1971.

Resolution 70M-14, from the 1970 House of Delegates, called for the Committee on Public Safety to prepare a compendium of recommended minimal standards for drivers. In 1968, the AMA published "A Physicians Guide for Determining Driver Limitations" which fulfills the intent of resolution 70M-14. Preparation of a separate compendium for Illinois would be a duplication of effort and an unnecessary expense. The Board of Trustees indicated that this should be communicated back to the House of Delegates in 1971. This manual, developed by the AMA, was co-authored by Norman J. Rose of the Illinois Department of Public Health, who is also with the Governor's Traffic Safety Advisory Board.

In a related matter, the Public Safety Committee backed strict enforcement of present regulations and legislation requiring school bus driver physical examinations. In addition, the Committee recommended and the Board of Trustees concurred, that additional regulation should be added to this legislation indicating that bus drivers of school vehicles may not be habitual users of amphetamines, narcotics or other habit forming drugs, except under medical direction and supervision.

Support was given implied consent legislation. In cooperation with the Committee on Alcoholism of the Council on Mental Health and Addiction, the Public Safety Committee recommended support to the Council on Legislation and Public Affairs through the Board of Trustees. The Committee still favors a medical review board for driver licensing and considered legislation proposed in



this field. However, no particular stand was taken since the legislation was still in development. It was recommended to the Governor's Traffic Safety Coordinating Committee that consideration be given uniform highway safety signs for emergency medical facilities. An emergency medical facility sign would be more effective than signs which would indicate hospitals and clinics. Mileage and directions to the facility should be indicated on all signs.

Support for the promotion of the teaching of first aid in schools was given. The Office of Public Instruction is preparing legislation to require the teaching of health in the schools and it was determined that this has been a four to six year study by the School Problems Commission. The Committee agrees with the concept of teaching health and first aid and would, of course, support legislation requiring the teaching of this subject. With the transition of government, due to the election of Mr. Bakalis, the problem will be reviewed again by the new superintendent with a view to implementing a new curriculum in this field for the 1971-1972 school year. Mr. Tom Janeway, of the Office of Public Instruction, indicated that legislation probably will be introduced in the 77th General Assembly to effect this. In any case, the Committee believes that some type of first aid course should be required in all schools at the junior and senior high school level. The Committee informed Mr. Janeway, who is director of health education, that the Medical Self-Help Program, available through the Illinois Public Health Department and the Illinois Civil Defense Commission, is the most comprehensive program in existence, and that school authorities should include this in the curriculum.

It was reported to the Committee that there is a movement on in Illinois to establish standards for training ambulance and emergency vehicle drivers. The National Academy of Sciences—National Research Council has compiled a bibliography on publications to be used in such training courses. In addition, the Chicago Chapter, American College of Surgeons, Trauma Committee is involved in establishing this course for Chicago police and fire department personnel. Dr. Albert Snoke, the Governor's coordinator for health services, announced a plan for state-wide emergency services. This was summarized in the March issue of the *Illinois Medical Journal*.

Several items remain as a concern of the Public Safety Committee. One is the use of protective corrective eye lenses. Others include snowmobile safety, ski-ing safety, leg lights for bike riders, booby trapped highways, and life support during extrication of accident victims.

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#### Committee on Child Health

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#### Committee on Maternal Welfare

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Gordon T. Burns	Donald M. Gallagher
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Robert Maletich	Richard Yoder
Hubert Magill	J. Roger Powell
Paul A. Raber	John C. Mason, Jr.
Harry J. Lewis	Donald R. Risley
James B. Stotlar	William R. Malony
John J. McLaughlin	Charles P. Westfall
John Louis	Augusta Webster

*Consultants*

Willard C. Scrivner	Franklin D. Yoder
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#### Committee on Nutrition

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Ben A. Kinsman	Alfred D. Klinger
Philip Lynch	Rene St. Leger

John E. Walters

*Consultants*

George Shropshire	Paul A. Dailey
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Max Klinghoffer	Julius Kowalski
Norman J. Rose	William J. Schnute
Clifford P. Sullivan	Mrs. Arthur Smith, <i>Auxiliary</i>

#### Ad Hoc Committee on Radiation

Howard C. Burkhead, *Chairman*

### ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The following is an abbreviated report on the programs and activities of the Illinois Department of Public Health. Employing approximately 1,100 professional, administrative, technical and clerical workers, the Department is charged with responsibility for leadership in the protection and promotion of the health of all the people.

The Division of Data Processing functions as a service agency to all bureaus and divisions of the Department. The primary objective is to provide quick and accurate information retrieval capability and statistical reports on health information important to planning, organizing, directing, controlling and coordinating program activity.

The State of Illinois, Department of Public Health, is engaged in the development of a Total Health Information System (T.H.I.S.) to expand and enhance the Department's present and potential capabilities. T.H.I.S. will be resident within the Division of Data Processing. The Total Health Information System concept is intended to provide the Department of Public Health and other agencies, both in the public and private sector, with a definitive plan for the modular evolution of a state-wide system to be developed on a multi-year basis. The plan is conceived to permit expansion of the system with minimum disruption of ongoing activities and to allow the Department to grow from its present computer configuration without system redesign or extensive reprogramming.

The eventual establishment of a single computer-based health information system will permit integration of demographic, public and private health resources, status and need data. The resultant integration of the aforementioned types of data into a single data processing



system will enhance the Department of Public Health's speed and accuracy in accessing large volumes of significant data and provide administrators with an expanded capability to perform planning, decision-making, investigative and regulative functions.

Initial implementation of selected program areas is scheduled for the fourth quarter of FY '71. As these areas are implemented, emphasis will be shifted to additional program areas.

### **Health Education**

Health education is that process whereby people are induced to alter or change their health habits and behavior. The bureau has the mission of providing public health workers at the state and local level with those educational and informational services best calculated to facilitate the understanding, acceptance and use among the population of the most up-to-date scientific information about health.

### **Community Health Resources**

The purpose of the Community Health Resources Program is to assist economically disadvantaged communities in the planning, development, and expansion of programs aimed at improving health services. A multi-disciplinary team of health professionals is available for consultation and technical assistance to community groups, local health departments and other agencies concerned with the health problems of the disadvantaged.

### **Local Health Administration**

The major responsibility of this division concerns the functioning of 48 autonomous county and multiple-county health departments and ten city and local district health departments. It serves in a liaison capacity for the Department's program directors and the local health departments, assisting in their implementation of Illinois Public Health Laws and Rules and Regulations through counseling and by providing channels of communications.

The division has the responsibility for administering standards related to programs, performance, and qualifications of personnel in local health departments.

### **Laboratories**

The division's activities are carried out by Sections on diagnostic services, sanitary bacteriology, biologic products, virus diseases and research, evaluation, and toxicology. The results of chemical, bacteriological and radiological examinations provide a continuing evaluation of the quality and safety of water (other than public water supplies), milk and other dairy products.

The division is also responsible for approving local independent laboratories, providing toxicological services to coroners and law enforcement agencies, testing biologic products and providing specialized reference and consultative services to other laboratories.

### **Health Planning and Resource Development**

The activities of this office will relate to planning of Department programs; to determining their impact upon the health needs being administered to; to studying improved methods and procedures; to establishing priorities; and to making cost-benefit analyses. This office will report directly to the Director's office and will perform in a staff capacity. This office replaces the Office of Comprehensive Health Planning which was transferred to the Governor's office.

## **Division of Family Health**

The Division of Family Health administers the following programs: Maternal and Child Health Program; PKU Program; Maternity Study Program; Family Planning Program; Premature and High Risk Infant Program; Vision Program; and Hearing Program.

The Maternal and Child Health Program has as its objective the priority of the health of women and children accomplished through consultation, education and certain direct services carried on in cooperation with local health agencies. This program is also responsible for consultation and supervision of the Federal projects in Chicago (Maternity and Infant Project 502 and Children and Youth Projects 601).

The PKU Program has as its legislative requirement that the Illinois Department of Public Health monitor the mandatory PKU testing program, assure follow-up and provide the dietary treatment for diagnosed cases.

The Maternity Studies Program administers the review of all deaths associated with maternity. A review of these maternal deaths is made by an obstetric consultant and a presentation of the study is made to the Maternal Welfare Committee of the Illinois State Medical Society. This provides a background for improvement of maternity services throughout the State of Illinois. The perinatal death studies attempt to identify, through statistical review, the problem of pregnancy wastage and early neonatal mortality. This program involves both obstetrics and pediatrics. It is a cooperative program with the Illinois State Medical Society.

The Family Planning Program is a relatively new effort of the Division of Family Health and is directed toward resolving the health problems related to unwanted pregnancies, and has the additional effort of contributing toward the solution of personal, public and environmental health aspects of the population crisis.

The Premature and High Risk Infant Program provides transportation to premature and high risk centers and total care for infants while in the center. It requires payment for this care according to the financial ability of the family. The program has just begun to serve newborn infants who are high risk in terms of morbidity and mortality regardless of weight in addition to premature infants.

The Vision Program entails: 1) promoting adequate vision screening of all children; 2) maintaining a Registry of Seriously Visually Limited Persons of all ages; and 3) promoting a public education program aimed toward correction of eye defects where possible, and the prevention of blindness.

The Hearing Program is concerned with the identification of hearing-impaired children early in life with the necessary referrals for early diagnosis and medical and educational management. This program is required by law—Senate Bill 324 (The Child Hearing Test Act).

## **Division of Disease Control**

The Division of Disease Control administers the following programs:

- Prevention and control of communicable diseases
- Prevention, control, treatment, case finding of venereal diseases
- Immunization program, including distribution of biologicals and the Federally funded Illinois Immunization program
- Medical Aspects of Traffic Safety
- Program for poison control (prevention of accidental



poisoning of children and treatment through establishment and direction of Poison Control Centers) Hazardous Substances Law, administration of

The Division monitors reporting of the communicable diseases ranging from venereal diseases to measles; promulgates rules and regulations for control; purchases and distributes biologicals for prevention; encourages and administers mass immunization programs; maintains surveillance of typhoid carriers, and of other diseases on a cooperative basis with the Center for Disease Control; promulgates rules and regulations related to compulsory immunization law; and provides consultation on communicable disease diagnosis, treatment and control, to local health departments, physicians and veterinarians.

The venereal disease control program's goal is to bring these diseases to an irreducible minimum in the state. Epidemiology and case finding have been intensified and educational activities expanded to meet the continuing increase in venereal disease cases.

The Division's section on traffic safety administers those programs related to the medical and allied medical aspects of traffic and automotive safety. Major program areas include the certification of state and local police officers in the operation of breath testing devices, the development of a coordinative system of Emergency Medical Services, and establishing programs regarding the problems of alcohol and drug abuse and their relation to highway safety.

The prevention and control of accidental poisoning in children includes the establishment of poison control centers in hospitals throughout the state, and direction of such centers in accordance with accepted standards.

### Health Facilities

The Division of Health Facilities has responsibility for the state licensing program of hospitals, independent laboratories, and long-term care facilities, which is directed toward the protection of the public through the development and enforcement of licensing standards. The Division is also responsible for the Medicare certification program of extended care facilities, independent laboratories, hospitals, home health agencies and portable X-ray units, out-patient physical therapy clinics, as well as certifying to the Illinois Department of Public Aid, health facilities eligible for reimbursement by the State.

In addition, the Division plans, directs, and implements the Geriatric Transfer Program, Medical Review Program, Hill-Burton Program, Rehabilitation Education Service Program, Packaged Disaster Hospital Program, and compiles vital data for the preparation of cost studies. Plans and specifications for all licensed health facility construction and planning are reviewed by the Division.

### Chronic Illness

This Division administers the cardiovascular diseases, rheumatic fever, cancer, glaucoma, diabetes and other chronic illness programs.

The Division also administers the Chronic Renal Disease Program which provides help to Illinois residents who suffer chronic renal failure. One million dollars is the current appropriation to fund dialysis treatments for patients referred by approved dialysis centers and artificial kidney machines are provided for patients on home dialysis.

### Tuberculosis Control

The Department maintains a current registry of all

reported cases. It has continued efforts to promote hospitalization of all active cases of tuberculosis; to secure the treatment of non-hospitalized cases; to insure the examination of contacts and suspects; and to encourage those infected to take chemotherapy in the form of INH for one year.

### Dental Health

In addition to the implementation and surveillance of the fluoridation legislation, the Division of Dental Health is currently involved in 10 other program areas. The primary emphasis is on education at all levels and prevention through various types of topical fluoride programs.

Care, on a limited basis, is provided to indigent and migrant children throughout the state by means of a self-contained two-chair mobile clinic.

A large portion of time is devoted to consulting work. Dentists or dental hygienists are available to assist local, state or federal agencies in the development of dental programs.

An approved residency program in Dental Public Health is also conducted by the division.

### Nursing

The Division of Nursing gives consultative and advisory service to all public health nurses in the state, including those employed by the Department, in schools and industries, in city, county and regional health departments and private agencies. It also is responsible for recruiting, training, and placing nurses; for continuous staff education; for developing sound professional standards; and for promoting leadership in the profession.

### Food and Drugs

The mission of the Division of Food and Drugs is the protection of the consumer—his health and his pocket-book.

By direction of the Sanitary Inspection Law of 1907, and the Illinois Food, Drug, and Cosmetic Act of 1967, the Division is responsible for sanitation and food hygiene in approximately 25,000 wholesale and retail food processing plants, e.g., canneries, bakeries, soft drink bottling plants, supermarkets, meat markets, etc. Inspection includes not only an examination of the plant and materials, but sampling of the product and laboratory analysis for adulteration or misbranding.

About 15,000 retail food service establishments, such as, restaurants, cafeterias and food catering operations are also inspected for cleanliness of premises, equipment, food and beverages.

The Illinois Food, Drug, and Cosmetic Act which became law on January 1, 1968, is regarded as a model law and makes Illinois a leader among the states in aggressive legislation to meet the challenges of a rapidly expanding area of consumer protection.

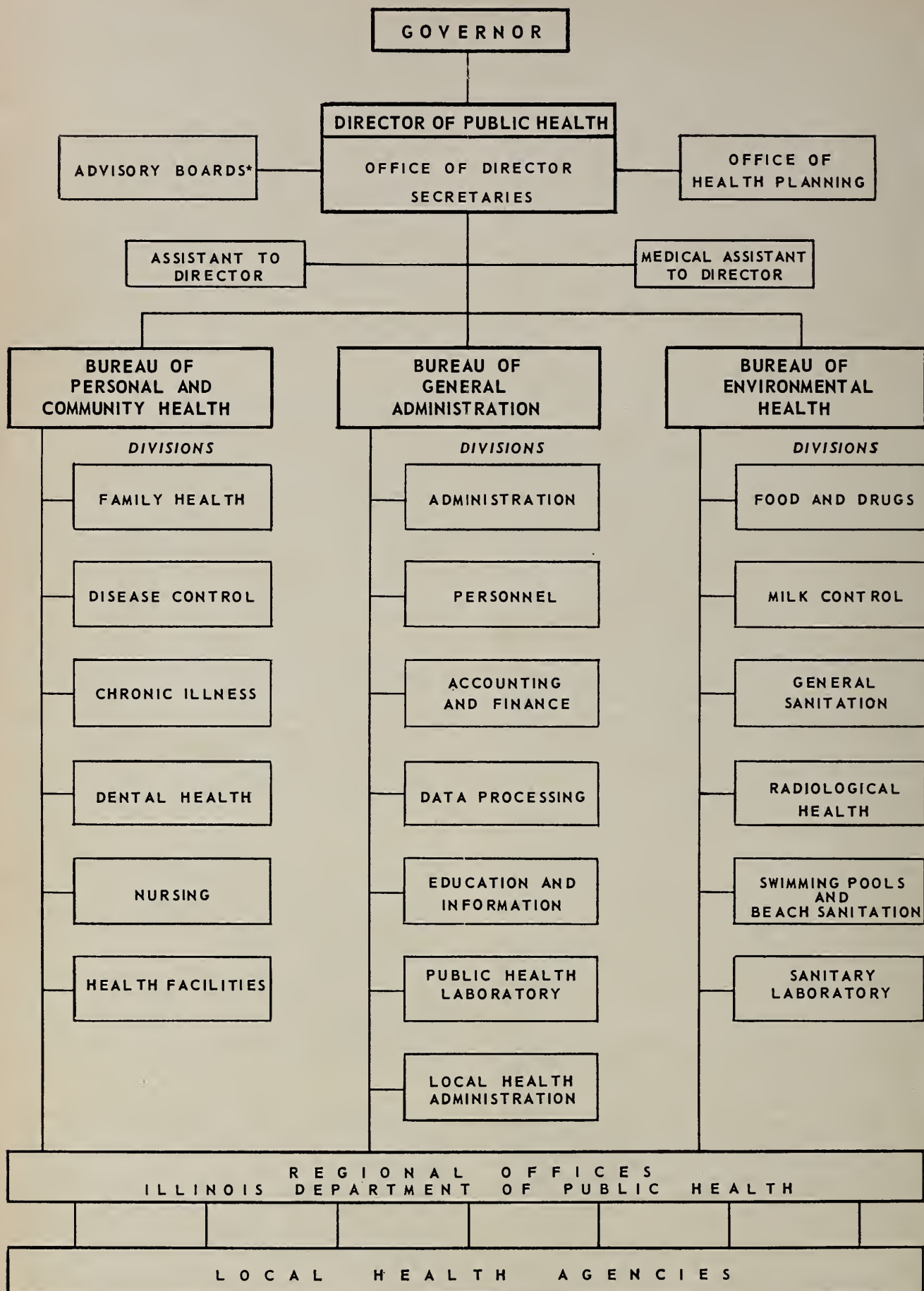
### Milk Control

It is the aim and the purpose of the Division to maintain a high level of sanitation for all milk supplies in order to assure the consumer of safe, wholesome dairy products.

The same degree of surveillance is applied to dairy processing and manufacturing plants. A certification program, supported by the Division of Milk Control in cooperation with neighboring states and the Federal Government, makes Illinois dairy products available for federal agencies, common carriers, and interstate shipment.



STATE OF ILLINOIS  
ILLINOIS DEPARTMENT OF PUBLIC HEALTH



### General Sanitation

This Division is responsible for environmental health programs affecting trailer parks, plumbing, migrant labor camps, water well construction and pump installation, private water supplies and waste disposal, insect and rodent control, sanitation in institutions and nuisance complaints.

Trailer parks are licensed and inspected annually. Regulations cover most of the areas of responsibility of a small municipality, including the park water system, sewers and sewage treatment, solid waste storage and disposal, park streets and street surfacing, park lighting, fire protection, trailer spacing and lot size. This regulatory program assures that these citizens are provided with a safe and sanitary environment.

The Plumbing Code Law authorizes the Department to prepare a model plumbing code that will provide protection to water supply systems and the Plumbing Contractors' Certification Law requires all plumbers to follow the code. This program is designed to protect water systems from contamination by back-siphonage and cross connections with hazardous supplies and materials.

The Migrant Labor Camp Law provides that migrant labor camps must be licensed annually and meet minimum standards of water supply, liquid and solid waste disposal, housing and vector control. Licensure and inspection programs are conducted to insure compliance with standards, to insure a healthful environment for these agricultural workers and to protect the surrounding community from unsanitary conditions.

The Water Well Construction Code Law and the Pump Installation Law requires the Department to adopt a code of regulations and practices for well construction and pump installation to insure a safe drinking water well for farmers, suburban dwellers, and others who must depend on their own well as a source of water. There are about 4500 wells drilled annually in Illinois. Inspections are conducted to determine location and construction as required by the code and requires the collection of samples of water for chemical and bacterial analysis.

Many environmental health services are also provided by the Division of General Sanitation which are not mandated by law. The entomologist acts as consultant to local municipalities in mosquito, rodent and other vector control. Inspection of the sanitary facilities at hospitals, orphanages and other child welfare institutions is included in the Division's activities. Consultation on safe and sanitary practices for private water supplies and for disposal of human wastes is also provided, including collection of samples for laboratory analysis. In addition

some 30,000 to 40,000 individuals annually submit samples from their drinking water wells to the laboratory for chemical and bacterial analyses. All of the results of such analyses must be interpreted and are reported back to the owner by the technical staff.

### Radiological Health

This Division is responsible for inspecting and regulating all installations with known materials or machines capable of emitting ionizing radiation. There are now 8,000 of these installations registered and they include all medical and industrial X-ray and isotope sources.

Division personnel also enforce the Radiation Monitoring Act which provides for maintaining a central registry for recording of radiation exposure records of persons working with radiation sources. Included in the activities is the responsibility for the supervision of the state owned radioactive waste burial site and the monitoring of the environment around this facility and other nuclear facilities in the State. Also within this division is the program for registration of laser systems which are used in Illinois.

The Division recently implemented a Peacetime Emergency Radiological Response Plan which coordinates the capabilities of six state departments from which necessary personnel and equipment can be drawn to respond to any nuclear incident which may threaten the health and safety of Illinois citizens.

### Swimming Pools and Beach Sanitation

The Public Swimming Pool Law administered by this Division is designed to insure the health and safety of all bathers in public swimming pools. The law authorizes the establishment of engineering design standards for the design of the pool structure, the water purification plant, bath house, pumps and appurtenances. This program includes consultation and control, beginning at the design stage for the public pool, complete to making regular inspections during the operation. The pool operator is required to complete and submit operational reports and to regularly submit water samples for laboratory analysis. Training of pool operators in proper pool operation, chemical and bacterial control of pool water, operation and maintenance of mechanical and electrical equipment, is conducted annually. Under this law, rules and regulations have been established and are enforced for the proper operation of the pool to insure a healthful sanitary place for recreation. Consultation and advice is also given to owners and operators of public beaches.

Franklin D. Yoder, M.D., *Director*

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## *Visit the Exhibits*



# finances and budgets

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## SECRETARY-TREASURER

To attempt to summarize or capsule in a few paragraphs the diverse activities of the Society for a year, in any fully complete manner, is practically impossible. This is particularly true for 1970. Expansion—extension—exploration—involvement—implementation—all are general and broad terms and all taken together comprise a wide expanse of activity. Yet, this represents only a portion of the ISMS field of action during the past year. The drastic changes constantly taking place in the status of governmental involvement in health care make yesterday's decisions and planning obsolete today. The new and ultra-complex systems and schemes evolving from every group, organization or governmental entity appear endless. If you or your fellow members feel confused or bewildered and are unable to understand or keep abreast of the various programs being proposed, pity the poor medical administrators or staff personnel who must attempt to somehow, some way analyze each and come up with predictable probabilities (or vice versa).

### Leadership Conference

In an attempt to bring some semblance of understanding, unity of definition and comprehension of the various methods being considered for the future delivery of health care, the Society sponsored a special Leadership Conference, the second in 1970, on Sunday, November 15, at the Continental Plaza Hotel in Chicago.

In cooperation with the Society's new Committee on Health Care Financing, the Conference brought together representatives from government, medicine, hospitals and the health insurance industry to address physician leaders from all parts of Illinois. A record number of 429 attended this Conference.

Government's views of future health care delivery were presented by Dr. Roger Egeberg, assistant secretary, Department of Health, Education and Welfare; and Emory Bullis, assistant to the director, Department of HEW.

Dr. Donald Harrington, medical director of the San Joaquin Foundation for Medical Care, presented his idea on health care delivery. The Foundation, established in 1953, pioneered this new method for delivering care.

The views of the health insurance industry regarding future health care delivery systems were presented by Louis A. Orsini, national director, Health Insurance Council; and Dr. Richard E. Anonson, president, Hennepin County (Minnesota) Health Care Foundation. Spokesmen for the hospital's point of view were Dr. Thomas H. Ainsworth, Jr., associate director, American Hospital Association; and James M. Ensign, vice-president, National Blue Cross Association.

Because of time limitations and the size of the audience, discussion of the various viewpoints was handled

by reactor panels which were composed of program participants and members of the Health Care Financing Committee.

No less successful was 1970's Leadership Conference No. 1, held February 8, at the Sheraton-Blackstone Hotel in Chicago, which also had a standing-room-only attendance. (Details concerning this meeting were described in the 1969 Secretary-Treasurer's report.) The interest manifested by such meetings and appropriate subjects is widespread and genuine, since the morning session, devoted to a Malpractice Symposium, and the afternoon meeting on Peer Review, provided less than adequate time for answering all questions and full discussion.

In view of the many variants being considered for the delivery of health care by the government and other organizations, and the rapid pace new plans or alterations of pre-existing programs are being proposed, it would appear that the number of Leadership Conferences should be increased so as to keep the membership alert and better informed.

### House of Delegates Minutes

At least once each year, a democratic body, consisting of elected representatives of the members, The House of Delegates meets for three days to study and discuss matters relative and pertinent to their mutual interest and welfare. Out of these deliberations come conclusions and decisions representing the agreements of the majority—which become the policy of the Society for the next year.

To insure accuracy of the actions of the House of Delegates, a complete stenographic record of each House session is obtained. As Secretary-Treasurer of the Society, I have reviewed this transcript to verify its accuracy and completeness. Any Society member who also wishes to review this record may do so upon request to the Secretary-Treasurer or the Executive Administrator. The 1970 transcript consists of 507 pages.

So that the delegates might have the major actions of the 1970 House quickly available to enable them to inform all members of their Society of the work of the House, an edited resume of the actions was mailed to each delegate within one week following the meeting. In addition, the July, 1970, issue of the *Illinois Medical Journal* contained an abstract of the transcript for the benefit of each ISMS member.

As has been the custom in the past, the abstract form of the 1970 minutes will be presented to the 1971 House of Delegates for approval.

### Communications

Unfortunately, no one has yet devised a test to fully



evaluate the effectiveness of an organization's communications efforts, such as isotopes are used in checking the circulation time. Unless a system is as thorough, as widespread, as dependable and as effective as the human circulatory system, and has no blockages in its network and encompasses a full return mechanism, it is not satisfactory to the organization nor of full benefit to the members.

Each year all prior communications programs are reviewed and re-evaluated. Errors are corrected and ineffective methods are eliminated. New ideas to bring information to members in the most direct and rapid ways are implemented.

The wide angle lens of overall information is the *Illinois Medical Journal*—published on schedule each month and sent to all members. In addition to its clinical articles are several sections pertinent to today's forum of medical practice. Added during 1971 were departments on Medical-Legal Review, Practice Management and Public Affairs Events. Previous standbys such as Membership Forum, Doctor's Library, Blue Shield Report, View Box, New Pharmaceutical Specialties and several others have been continued. Soon to be added will be the "Peer Reviewer," supplying current information concerning peer review activities.

In more direct focus is the "Pulse," an eight-page leaflet which abstracts and highlights Society events and activities in addition to a special section for Auxiliary news. A former publication, "What Goes On," discontinued about two years ago because of lack of sponsorship, has now been reestablished as a section of the *IMJ*.

In telephoto emphasis, supplementing but magnifying the regular publications, are the Society's special bulletins and newsletters. These deal with specific divisions or activities. The *Legislative Newsletter*, dealing with pros and cons of current legislation, is published during the legislative months. Taking its place when the legislature is not in session is the new *Government Affairs Digest* (which incorporates the former "Public Affairs Newsletter."). New for 1970 is *Hot Line*, a flash sheet primarily for county society administrators, and the *Peer Reviewer*, dealing specifically with items concerning Peer Review. In addition, special meeting notices are sent as the occasion demands.

Topping the list from a direct and personal communication standpoint is the President's Tour. The 1970-71 Tour took Dr. J. Ernest Breed on a crisscross journey through the state. Over a six-month period, a team consisting of Dr. Breed; Mrs. Wilson West, ISMS Auxiliary president; Miss Ina Yenerich, IMAA president; a member of the Medical Liability Committee and the Society's legal counsel; and members of the Public Affairs Committee, in addition to staff members, visited every trustee district except one. Due to unusual difficulties, the tour meeting for the Eighth District was cancelled.

The afternoon program featured a 90-minute discussion on forthcoming medical legislation and public affairs activities and a second session of equal length on malpractice. This included a unique tape-slide presentation and an evaluation of the current legal outlook on physician liability problems.

In a further effort to increase communications, Dr. Breed met with county society officers and the district trustee at every tour meeting. This was intended to increase the dialogue between county societies and the state office.

### Illinois State Fair

Again in 1970, as has been the case for over 20 years, ISMS maintained a booth at the Illinois State Fair in

Springfield. This is the Society's only large physical exposure to the public and is done to carry public health and good health advice to the many thousands who visit the State Fair each day. The 1970 theme was drug abuse. In addition to six-foot-high photo murals depicting the hazards of drug usage, six different pamphlets were distributed. These were produced in the ISMS print shop, in quantities of 25,000, to alert parents and children to the dangers of the wrongful use of particular pharmacologic compounds and elements. Of great interest was a special display of actual drugs used by addicts, classified as "uppers" and "downers." Each drug was identified by both its trade name and the designation given it by addicts (i.e., "red devils," "speed," "bennies,"). For security, the display was mounted under glass, and removed and locked up at night. The exhibit was extremely popular and several thousand persons visited the ISMS booth.

### Membership Records System

The Society has just completed its fifth year of direct dues billing and collection system. Each year has seen improvements in this system, both in accuracy and on a time-savings basis. The results of this are greater yields of a greater number of accurate and varied dues payment reports on a well-scheduled basis. For 1971, 75 component societies have availed themselves of the complete billing service and printed dues forms have been provided for 15 others for their local handling.

The computer program accomplishes much more than dues billing. It generates many sets of membership address labels each month, and the continued use of a carbon technique provides multiple copies at an extremely low cost per label. As stated in previous years, the Society has no data processing equipment of any kind. The data is prepared on a master tape file, which is the property of the Society, and which can be used on any of the latest makes of computers now in general use. The master tape is designed, if and when the need arises, to contain much more information than it now contains, the only cost being that of the necessary programming. Depending upon the amount of detail needed, it probably would be adequate to serve the Society's needs should it enter upon a Medical Care Foundation program.

In addition to the above, rosters of members are prepared periodically in a variety of formats for internal reference, thus enabling staff to perform a myriad of assignments not possible prior to the introduction of this system. During the past year, by grouping and timing tape input and corrections, tape maintenance costs have been reduced considerably.

Membership records are now 100% computerized. In addition, the membership of the Illinois State Medical Society Woman's Auxiliary and the Illinois Medical Assistants Association have been added. These two organizations are provided mailing labels and rosters as they are needed. Also provided, almost on a daily basis, is the medical education number of Illinois physicians to pharmacies and other institutions to facilitate their filing state and federal forms, such as the IDPA.

### Condolence Letters

ISMS has continued to send an individually typed and personally signed letter of condolence, properly worded to fit the occasion, to the families of all deceased members. Many gracious and appreciative replies have been



### Membership Statistics

Changes in ISMS membership statistics for the past several years, as recorded in the Society's records, are indicated in the accompanying table.

	1970	1969	1968	1967	1966	1965
Membership as of January 1 .....	10,650	10,627	10,568	10,607	10,626	10,500
New Members .....	354	370	425	515	517	492
Reinstatements .....	28	46	40	43	65	43
Total added .....	382	416	465	558	582	535
Dropped during the year:						
Died .....	145	190	205	211	191	172
Moved from State .....	73	66	50	151	172	101
Resigned .....	12	13	6	12	21	28
Nonpayment .....	110	124	145	223	217	108
Total dropped .....	340	393	406	597	601	409
Membership as of December 31 .....	10,692	10,650	10,627	10,568	10,607	10,626
Regular .....	9,405	9,389	9,375	9,335	9,417	9,492
Residents .....	207	223	196	214	250	278
Service .....	126	101	105	59	51	26
Emeritus .....	463	472	507	514	484	491
Retired .....	456	434	403	399	349	334
Hardship .....	35	31	41	47	52	45
Intern .....					4	20
Total .....	10,692	10,650	10,627	10,568	10,607	10,626

received from these expressions of sympathy.

Other routine personalized and individually signed correspondence have been letters sent to each member elected to emeritus, retired or cancellation of dues status.

### Membership Statistics

The changes in membership statistics are indicated in the accompanying table.

Changes in the number of Society members are subject to many outside influences, such as the attractiveness of Illinois as an environment for medical practice and the general economics and population growth of the state. Membership has continued approximately the same over the past three years. It is regrettable that Illinois educates a sizable number of physicians (with Illinois tax dollars) who later elect to practice elsewhere.

No Illinois physician, whether in governmental, administrative, industrial or active practice, should feel that he can permit himself the luxury of not playing an active personal role in medical society affairs. His participation is needed in order to avoid the splintering of influence that leads to unsound changes in the role of the physician in society. With all levels of government so deeply involved in the distribution of medical services, the State Society must be the unified speaking voice of the physician, if a voice is to be heard and recognized. This should be especially true of our academic colleagues, who should be examples of the highest degree. They owe the profession, in general, this obligation. Unfortunately, many choose organizational isolationism.

The Society's services and benefits are well-defined in a fine brochure recently completed by the Society's Public Relations Division. A supply of these was sent to county secretaries in 1970.

### Financial Statements for 1970

Condensed financial statements are presented here for the benefit of the entire membership. The complete and detailed audit report prepared by Peat, Marwick, Mitchell & Company for the year ending December 31, 1970, will be distributed to the members of the House of Delegates prior to the meeting and is available for review at the Headquarter's Office by any member upon request. A copy of the preliminary December 31, 1970, Year-End Financial Report of ISMS (prior to audit) containing the 1970, and 1971, budgets was provided by mail to each delegate during January, 1971. This is in keeping with the expressed request of the House that such information be provided no less than 60 days prior to the Annual Meeting of the House of Delegates. This will enable delegates to review the Society's financial position, results of operations, and future planning well before the actual Reference Committee hearings.

As each physician must know from experience in his own practice, the Society has been experiencing a steady increase in "the cost of doing business" because of inflation. The December release from the U.S. Department of Labor shows the Bureau of Labor Statistics index 5.5% above the level of a year ago.

In analyzing the Society's income and expenditures, and the evaluation of the 1971 budget, it might be well to briefly review the apportionment of the Society's income.

At the time of the last dues increase (which was effective for 1966) a five-year plan was set up in accord with a recommendation from the House of Delegates. Of the \$105.00 annual dues, \$70.00 was to be used for the Operating Fund, \$20.00 allocated for AMA-ERF, \$7.00 added to the Benevolence Fund, and \$8.00 set

# **Illinois State Medical Society Position Statement—Dec. 31, 1970\***

<i>ASSETS</i>	<i>Operating Fund</i>	<i>Benevo- lence Fund</i>	<i>Perma- nent Reserve Fund</i>	<i>Property Fund</i>	<i>Student Loan Fund</i>	<i>Suppl. Emp. Retire- ment Fund</i>
Cash	261,198.33	255.00		12,171.94		26,614.34
Receivables	22,324.67	381.39	2,409.59		122,728.61	
Investments, at cost		261,891.85	612,458.54			
Student loans						
Prepayments and advances	9,915.61					
Office Furniture and Fixtures				93,592.55		
Interfund Receivables (Payables)	28,677.96	20,571.09	96.00	8,010.87		
<b>Total Assets</b>	<b>264,760.65</b>	<b>283,099.33</b>	<b>614,964.13</b>	<b>113,775.36</b>	<b>122,728.61</b>	<b>26,614.34</b>
<b><i>LIABILITIES AND FUND BALANCES</i></b>						
Payables	204,880.47					
Accrued expenses	5,454.54					
Deferred income	25,112.00	1,045.00				
<b>Fund Balances</b>	<b>29,313.64</b>	<b>282,054.33</b>	<b>614,964.13</b>	<b>113,775.36</b>	<b>122,728.61</b>	<b>26,614.34</b>
<b>Total Liabilities and Fund Balances</b>	<b>264,760.65</b>	<b>283,099.33</b>	<b>614,964.13</b>	<b>113,775.36</b>	<b>122,728.61</b>	<b>26,614.34</b>

## **Income Statement—Operating Fund—Year Ended Dec. 31, 1970\***

<i>INCOME</i>		<i>EXPENSES</i>	
Membership dues—		Board and Officers	46,348.11
Basic Dues—\$105 per member	983,424.00	ISMS Meetings	36,363.42
Plus Allocation from Contingency Reserve	28,724.00	AMA Meetings	24,967.88
		Administration & Business Services	134,284.50
<b>Total</b>	<b>1,012,148.00</b>	Business Services—Management Services	131,825.69
Less Allocations		Public Relations & Economics—P.R.	77,471.00
AMA-ERF—\$10 per member	93,620.00	Public Relations & Economics—Econ.	29,737.72
ISMS Program for		Legislation & Public Affairs	59,347.14
Unmet Medical Needs—\$10 per member	93,620.00	Springfield Regional Office	54,135.00
HCCI—\$2 per member	18,724.00	Educational & Scientific Services	46,220.29
Benevolence Fund—\$3 per member	28,086.00	Publications	34,242.21
Permanent Reserves—\$8 per member	74,896.00	<i>Illinois Medical Journal &amp; Pulse</i>	216,464.41
Subscription to IMJ—\$2.50 per member	23,405.00		
<b>Total Allocations</b>	<b>332,351.00</b>	<b>TOTAL EXPENSES</b>	<b>911,407.37</b>
Net Membership Dues	679,797.00	<b>EXCESS OF INCOME OVER</b>	<b>15,403.31</b>
Illinois Medical Journal	145,913.20		
"Pulse"	29,600.00		
Annual Convention Exhibits	13,885.00		
Interest and dividends	36,860.94		
All other	20,754.54		
<b>TOTAL INCOME</b>	<b>926,810.68</b>		

\*Unaudited.

aside to build up the Permanent Reserve Fund. At that time, in a wise and far-sighted move, a Contingency Reserve Fund was established by the Finance Committee and Board, whereby \$2.00 was set aside in 1966, \$1.00 in 1967, and none in 1968. A return to the Operating Fund of \$1.00 in 1969, and \$2.00 in 1970, was planned. This was to be used as a cushion against increased cost of doing business and inflation.

The recommendation of the House to transfer \$10.00 of the \$20.00 1970 dues allocated AMA-ERF to the ISMS Educational and Scientific Foundation "to coordinate promotional efforts to end the shortage of physicians and to develop programs to furnish facilities and manpower in 'health deprived' areas" has been followed. As of

December 31, 1970, the balance in the Contingency Reserve that was set up in the 1966 dues increase has been depleted.

A copy of the projected budget for 1972, will be provided to each member of the House in advance of the 1971 Convention. It should be noted that while the budgets developed for 1971 and 1972 are in balance, some projects and programs have been curtailed or eliminated and no funds are available for any new projects. As stated in previous reports, should the House of Delegates direct any new programs of a major nature, a recommendation as to the method of providing the necessary finances for them must also be provided by the House at the same time.



### Appreciation and Thanks

The ISMS staff are "good people." They have consistently worked for the betterment of medicine in Illinois, have diligently and successfully helped to elevate the progressiveness of the Society and have shown willing cooperation with the officers, trustees and members. A grateful word of sincere appreciation for another successful year is due Mr. Roger N. White, executive administrator, and his faithful staff. The Illinois State Medical Society can be proud of its outstanding medical prominence, thanks to the initiative of both physicians and staff.

Jacob E. Reisch

### BENEVOLENCE COMMITTEE

During 1970, the Benevolence Committee carried on its list of recipients thirty-one widows and only two physicians. During the year, two of the widows were removed, one died, and four new recipients were added.

The average total monthly payment to recipients was \$5,695 and the financial audit of the Committee and its assets appears with the report of the Treasurer, as prepared by Peat, Marwick and Mitchell, auditors of various ISMS accounts.

The investments of the Committee are made by the Trust Department of the Continental Illinois National Bank & Trust Company, and the custodial account

charges are paid from the general funds of the Society, since monies paid into the Benevolence Fund cannot be paid to other than a recipient, according to the existing Bylaws under which this committee operates.

When the expenses of this committee are studied by the Reference Committee on Finances, Budgets & Publications, the rulings under which the committee functions will be called to its attention.

After a questionnaire was sent to all recipients last year, the results were studied by the committee, meeting at the headquarters office. It was deemed very necessary that most of the recipients be given an increase in their payments, due to inflation and the rise in the cost of living. These increases became effective with the July 1, 1970 payment. It should be noted that the Chicago Medical Society is assisting with payments for Chicago Medical Society members on our list. This assistance was made possible by a bequest of the widow of a CMS member for the recipients of benevolence within Cook County.

The Woman's Auxiliary has always been of outstanding assistance to the committee, not only in providing funds, but also in giving personalized assistance to many of these elderly people who not only need money, but also the association with members of the profession and their wives to extend understanding and friendship, as well as material needs.

Keith H. Frankhauser, *Chairman*

Allison L. Burdick

Leo P. A. Sweeney

## Medical Self-Testing for Physicians

**University of Illinois Center for Educational Development** will test your knowledge in a wide variety of subjects in Round Table 1—lower level—beneath the main exhibit hall.

**9:00-5:00 p.m. Monday, Tuesday & Wednesday**

**Wyeth Laboratories Autotutors** will be operating in the Biff Room to test your knowledge of office gynecology, liver function, dermatology, and thyroid diseases.

**9:00-5:00 p.m. Monday, Tuesday & Wednesday**

**USV Pharmaceutical Corporation** will present a 3 part continuing education project on diabetes

**10:30 a.m. - Monday, Tuesday & Wednesday**

# legislation and public affairs

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## COUNCIL ON LEGISLATION AND PUBLIC AFFAIRS

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The Council on Legislation and Public Affairs has met several times since the last meeting of the House of Delegates. Following each meeting the Council has reported in detail to the Board of Trustees and to the membership through the special legislative newsletters, "On the Legislative Scene" and the "Governmental Affairs Digest."

### Federal Legislation

Your Council, through its chairman and other officers of the Illinois State Medical Society, through routine contacts with the AMA and personal contacts in Washington, has maintained a close working knowledge of Federal legislation related to medical care.

The 91st Congress adjourned on January 2, 1971, only one day before its automatic expiration. Lacking agreement by the House and the Senate, the Social Security amendments of 1970, H.R. 17550, died at the close of the Congress. Passed by the House on May 21, 1970, it was not reported to the Senate by its Finance Committee until December 11. As sent to the Senate floor, it included increases in Social Security cash benefits, extensive Medicare and Medicaid amendments, tariff and trade provisions, major welfare reforms, and Senator Long's amendment for a national program of catastrophic illness coverage. After other provisions were deleted, the Senate passed cash benefit increases and Medicare and Medicaid amendments (including Senator Bennett's PSRO amendment). However, the bill did not pass until December 29, too late to survive the conference process.

President Nixon has indicated that health programs will be a major concern in 1971. On February 18, the President sent to Congress his health message containing wide-ranging health proposals. Included in the message was a proposal to require employers of one or more persons to provide minimum standard health protection for employees and their dependents; legislation which would provide basic health insurance protection to all low-income families with children not covered by employer plans, with uniform nationwide eligibility, and with upper income cut-off at \$5,000 (for a family of four). The President also advocated the establishment of HMOs as an effective means of providing health care. Included in the proposals was an increase on the wage base for Social Security taxes to \$9,800, the appointment of a Commission on Medical Malpractice, and a Conquest of Cancer Act, appropriating \$100 million.

To meet the personnel needs of the health system, the President recommended aid to medical schools, guaranteed loans for construction grants, special programs to help low income students enter medical and dental schools, and a \$15 million line item devoted to the training of physicians assistants. National health insurance seems to

be the most popular item in the current session of Congress with the Kennedy-AFL-CIO Plan, the American Medical Association's Mediredit Plan, and the President's program receiving the greatest amount of interest. The Health Security Act introduced by Senator Kennedy would provide benefits to every resident of the United States and every non-resident within the U.S. The bill would include primary medical services and specialized services furnished by physicians, psychiatric services if furnished by a comprehensive health service organization or other approved facilities, or up to twenty consultations for ambulatory care. The bill would authorize \$200 million for fiscal 1971, \$400 million for fiscal 1972, and \$600 million for fiscal 1973. The Mediredit bill, introduced by Congressmen Fulton and Broyhill, is proposed to incorporate into a single bill programs for: (1) the financing of health care for low income persons; (2) cash incentives through tax credits for the acquisition of comprehensive insurance health coverage; and (3) a structured statewide system for peer review of utilization, charges and quality of services. Mediredit would replace the Federal and state financed Medicaid program, but would continue Medicare with the premiums now paid by the aged, paid in full by the government for the low income aged, and in part for the others.

Pending legislation at the time of the writing of this report include H.R. 1, social security amendments of 1971 which failed to pass during the last session of Congress. Upon enactment into law these amendments will become effective retroactive to January 1, 1971. As was previously indicated, these amendments provide increased cash benefits, modifications in Medicare and Medicaid, the PSRO Bennett amendments and changes in maternal and child health programs.

H. R. 817 would provide for federal reinsurance for the cost of catastrophic illness coverage. H.R. 4156 would expand and extend medical facilities, construction grants and the student loan and scholarship program.

Senator John Tower (R-Texas) has introduced S.B. 576 which would provide tax exemptions for physicians practicing in medically deprived areas. The bill provides the first \$20,000 of adjusted gross income of a physician which is derived from medical practice would be tax exempt for the first taxable year of practice in an established physician shortage area. This tax incentive would continue for five years, with decreasing incentives for each successive year in that period. Minimum length of service by a physician under the program would be two years.

Finally, the administration has introduced the Drug Identification Act of 1971, which would establish a coding system to identify all prescription drugs.



1971 has been described as the year of health legislation. No doubt medicine will receive much abuse from a variety of sources during this coming year. We must not only be prepared for both immediate response to false allegations and maintaining a controlled reaction, but taking the initiative whenever possible.

### State Legislation

During the 1970 House of Delegates, your Council reported the status or results of proposed legislation affecting medicine, physicians and the health of the citizens of Illinois. On April 1, 1970, the Legislature convened for the purpose of a special fiscal session. Most bills considered, dealt with either revenue or appropriation matters. In this special session one of the two most important bills introduced and passed at the urging of ISMS was S.B. 227, which gave the Cook County Hospital Governing Commission complete control of the hospital's budget, hiring and firing of personnel, purchasing, and the right to ask the county board to authorize a tax levy of up to \$.25 per \$100 assessed valuation.

On June 18, 1970, Governor Ogilvie signed S.B. 227 at Cook County Hospital. Among the many in attendance at the signing of this bill were Drs. J. Ernest Breed, president of ISMS, and Philip G. Thomsen, M.D., active member of the Cook County Hospital Governing Commission.

The second bill introduced and passed on behalf of the Illinois State Medical Society was S.B. 1425, which exempted medical student loans from the State's Usury Law.

Other legislative proposals passed during the special session included a series of bills sponsored by Rep. George Burditt, (R-LaGrange) cited as the "Environmental Protection Act." The Act covers such areas as the regulation of air pollution, water pollution, public water supply, land pollution, solid waste, noise and atomic radiation. The bills also established an Environmental Protection Agency, a Pollution Control Board and an Institute for Environmental Quality.

Also passed was an \$8 million appropriation to non-public health facilities and a \$6.1 million reappropriation to the Chicago Medical School for facility expansion.

We are presently engaged in the first hectic months of the 77th General Assembly. The number of bills introduced is expected to run close to 8000, as opposed to 4000 filed during the last General Assembly. The 76th General Assembly considered over 300 proposals affecting medicine, 75 of which were determined to be of primary importance to medicine. The estimates for this 77th Session indicate possibly 500 bills affecting medicine and over 200 of primary importance.

Several court decisions will promulgate legislation of which physicians must be aware. Probably, the single most significant decision was the case of McNeal Memorial Hospital, which, in effect, made hospitals, blood banks, physicians, technicians and even donors strictly liable for potential hepatitis contracted following the infusion or transfusion of blood. In cooperation with the Illinois Hospital Association, ISMS has introduced legislation, H.B. 16, which would remove the strict liability resulting from the transfusing of blood and transplanting of corneas and organs in the absence of negligence. It is your Council's firm belief that this legislation will re-establish the necessary freedom for physicians within the medical environment.

One of the biggest news stories of the year was the First Federal District Court's decision that the Illinois Abortion Statute was unconstitutional. Although a stay

order has been instituted by the Supreme Court of the United States, the result of that decision has been a plethora of legislation aimed at liberalizing Illinois abortion laws. This legislation is not new, as a matter of fact it has been introduced year after year and reviewed by your Council. Not one bill introduced on the abortion issue has encompassed the stand of your society, and as a result, your Council has not supported pending abortion legislation.

A third court decision affecting the practice of medicine has been handed down in the case of *Mathis vs. Hejna*. In this decision, it was ruled that pantopaque introduced into the body for the purpose of a myelogram was a foreign substance within the meaning of the law. The effect of this ruling is that physicians who introduce such things as pantopaque, or metal pins for orthopedic surgery, pace-setters for defective hearts and even plastic tubing, used in aneurysm resectionings, would be liable for any defect of the product. Your Council has introduced legislation which would limit the liability when the physician has *purposely* introduced such foreign substances and intended them or parts of them to remain.

Your Council has given support to legislation certifying the title of Physician's Assistant. This bill allows for nurses and medical corpsmen to take the exam without the educational training required of other applicants, but no physician may employ more than two physician's assistants. The physician's assistant may be located in a neighboring community, but the physician is responsible for any and all acts of the assistant in the practice of medicine. Although not a panacea to the manpower shortage problem, it may provide symptomatic relief.

Legislation has been introduced and is being supported by ISMS that would require the labeling of all prescription drugs to contain the name of the drug, the potency, and amount, unless specifically excepted by the physician. The present practice of omitting the above information may, and in some cases has, led to poisoning or death because treatment could not be based on accurate data. ISMS believes this legislation is in the public interest although the physician should have the prerogative to establish certain exceptions.

Two bills dealing with school children will be introduced, which ISMS hopes may better provide for the health and welfare of the school children of this State. Because the Illinois School Code provides that children must receive physical examinations prior to entry into kindergarten or first grade and fifth and ninth grades or upon first entering school, physicians' offices are flooded every year prior to school time. The effect on the public is long waiting periods, loss of school time if the exam is performed after the school year, and strain on the time of the physician. Further, the physician may better benefit the sick if less time was spent on such exams during this short two month period. ISMS seeks remedial legislation to better distribute these examinations throughout the year.

The second piece of legislation is a bill which would create a statutory requirement that all school bus drivers for public, private and parochial schools receive an annual physical examination. Although various school code regulations for state reimbursement of transportation costs may require such exams, ISMS feels the wording is insufficient. It is the intention of ISMS to support this legislation to provide the school children of this State a maximum of safety, and provide whatever pressure is needed to see the laws are enforced.

In addition, your Council supports an Implied Consent



Law, which defines application for a driver's license to mean that the applicant automatically gives his consent to be tested for intoxication if requested to do so by a law enforcement officer resulting from his operation of an automobile. Refusal to do so results in revocation of the license.

There have been numerous measures introduced in regard to the classification of marihuana and the penalties for use and pushing of this drug. Based on the recommendation of various committees and councils of ISMS, your Legislative Council has indicated its support for lessening of the penalties for possession and increasing the penalties for pushing, specifically to those under 18.

Legislation has been introduced to make the already unethical practice of fee splitting an illegal act and grounds for revocation or suspension of license under the Medical Practice Act. Although your Council feels that this legislation is unnecessary, ISMS supported the bill, with amendment to indicate involvement of ISMS with the Dept. of R&E.

### CORONER STUDY

A special ISMS Ad-hoc Committee has been appointed to study the possibility of establishing a medical examiner system for Illinois, supplanting the present coroner system. The Committee has requested that the chairman of the Medical-Legal Council and the chairman of the Committee of Laboratory Services serve on this special ad-hoc Committee and that the Committee look into the development of post graduate courses in forensic medicine.

### EYE HEALTH

The Eye Health Committee has met on numerous occasions during the past year. One such meeting was a discussion with Dr. Mizner, president of the Illinois Optometric Association, to discuss mandatory office eye exam for all school children in the State of Illinois. At that time, your Council recommended that such an exams was not in the best interest of the school children of this State.

A discussion of the Plano Center for Vision indicated their desire to sell a visual training program by optometrists to the Chicago School Board. Again, your Eye Committee felt that this was not in the best interests of the health of Chicago school children. Finally, the Committee has cooperated in the development of an Illinois Association of Ophthalmology which will cooperate with the Eye Health Committee of the Illinois State Medical Society in dealing with problems in the area of ophthalmology. This organization has worked closely with the Eye Committee in the discussion of H.B. 203, the licensing of opticians in this state, and the general eye health of the patient.

### EAR, NOSE & THROAT

This new Committee, established by the House of Delegates in 1970, has met on numerous occasions and has accomplished or is in the process of accomplishing the following objectives:

1. The Committee considered and approved the position of the Chicago Laryngological and Otological Society with regard to permissible environmental noise levels published in the December issue of the *Illinois Medical Journal*.
2. A bill to certify Hearing Aid Dealers and Fitters has been considered and reviewed by legal counsel and shall be presented to the Legislative Council in the

near future. Should the Legislative Council and the Board of Trustees approve the legislation, your Committee will present the bill to the Hearing Aid Dealers for their introduction into the General Assembly. The Committee feels that this is a positive approach rather than opposing this sort of legislation year after year.

3. In the near future, the Committee plans to participate in the development of statutory regulations of permissible noise levels.

### PUBLIC AFFAIRS

The ISMS Public Affairs Committee has met several times since the 1970 Annual Meeting. To aid the physician and his wife in political education and activity, a comprehensive program was developed and implemented. A brief outline of that program is as follows:

**Meetings:** Each County Medical Society was encouraged to sponsor a Public Affairs Program during the year. A list of audio-visual materials and booklets is available for program planning. As part of the 1970 President's Tour, a Public Affairs Workshop was presented to familiarize physicians and their wives with ISMS programs, and to inform them of current political activities such as legislation and Con Con. Further, the Public Affairs Committee has encouraged staff visits to various County Society meetings to discuss pending legislation and its effect on the practice of medicine.

**Monthly Newsletters:** During 1970, over 2500 physicians received monthly newsletters on political topics. The *Governmental Affairs Digest* was developed to consolidate numerous other newsletters to bring physicians behind the scenes of current political developments and personalities. During the Illinois legislative session, this newsletter is replaced by *On The Legislative Scene*, which reports House and Senate Floor action, committee recommendations and newly introduced bills which may affect physicians in the practice of medicine.

### Washington Roundup

The annual Public Affairs Roundup was to be held in conjunction with the U.S. Chamber of Commerce on April 25-28, in Washington, D.C. The basic agenda for the Roundup entailed ISMS and AMA staff presentations, visitation periods with the respective congressmen and senators, and a luncheon with the Honorable Donald Rumsfeld, advisor to the President.

### Key-Man Program

The new Key-Man program, developed by your Public Affairs Committee, is being implemented to emphasize the importance of a personal physician-legislator relationship. This new plan calls for at least one physician to be assigned to each of the 24 Illinois Congressmen, 58 State Senators and 177 State Representatives. The Key-Man will communicate with his legislator regularly so that the legislator will know exactly where medicine stands on various issues. The ISMS Legislative Division will be in constant contact with the Key-Man through various means, placing him on a special mailing list to receive legislative alerts, regular issues of *On The Legislative Scene* and *Governmental Affairs Digest*, and via telegram and telephone.

### Auxiliary Program

Under the direction of Auxiliary Public Affairs Chairman, Mrs. Patricia Failor and Legislative Chairman, Mrs.



Pamela Taylor, the Auxiliary had another active year in Public Affairs activities. A first, this year, was the Auxiliary Public Affairs Breakfast in conjunction with the ISMS Annual Meeting. James Sammons, M.D., Texas, former chairman of AMPAC, was the principal speaker. An unusually large turnout of Auxiliary members participated in this new program.

#### **Annual Public Affairs Dinner**

A Public Affairs Dinner is held annually during the

ISMS Annual Meeting in May. Last year approximately 400 physicians heard U.S. Senator Ralph Smith, and political satirist Art Buchwald speak on national issues. This year Lt. Governor Paul Simon, and political satirist Mark Russell will be the featured speakers. A special thanks is extended by the Public Affairs Committee to the fine staff of the Illinois State Medical Society for the time and effort devoted to the success of our numerous public affairs functions.

#### **Council on Legislation and Public Affairs**

Alfred J. Faber, *Chairman*

Frank Holman	Frank J. Kresca
Richard Allyn	Eugene J. Scherba
John Ovitz	James Ryan

Warren Tuttle

*Consultants*

C. J. Jannings, III	Fredric D. Lake
Frank J. Jirka, Jr.	William M. Lees

James B. Hartney

Mrs. Alan Taylor, <i>Auxiliary</i>	Mark Brakke, <i>SAMA</i>
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#### **Committee on Public Affairs**

John Ovitz, *Chairman*

Herbert Sohn	William Ashley
William W. Boswell	Herschel L. Browns
James E. Coeur	Edwin L. Falloon
Justin Fleischmann	George J. Gertz
J. R. Shackelford	Philip Boren
William J. Hillstrom	Rocco Lobraico
Earl V. Klaren	W. Robert Malony
Charles Downing	James D. Rogers
Earle Walker	Stanley E. Ruzich
Robert M. Geist	John L. Savage
Julius P. Schweitzer	Lee Winkler
Eugene H. Siegel	Lorin D. Whittaker

*Consultants*

Theodore Grevas	L. T. Fruin
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Frederick E. Weiss

*Auxiliary*

Mrs. J. J. Failor	Mrs. Harry Parks
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Steven Lipnik, *SAMA*

#### **Ear Nose & Throat Committee**

John J. Ballenger, *Chairman*

George H. Conner	Paul H. Holinger
Richard E. Marcus	William A. Weiss

Guy O. Pfeiffer

*Consultants*

Meyer Fox	Earl Harford
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Maurice Hoeltgen

#### **Eye Committee**

Frank J. Kresca, *Chairman*

David L. Brown	Wilbur W. Baumgartner
James R. Fitzgerald	Max Hirschfelder
Edward Kwedar	Lawrence J. Lawson
Charles L. Pannabecker	Manuel L. Stillerman
M. Byron Weisbaum	Maurice M. Hoeltgen

William A. McNichols, *Consultant*

#### **Coroners System Study Committee**

Eugene Scherba, *Chairman*

Thomas P. DeGraffenried	Seymour Glagov
Harry Kinser	David Kinzer
Edwin Hirsch	Edward Piszczek
Robert Wissler	Richard Allyn
Grant C. Johnson	Martin Swerdlow
James Ryan	Frank Pfeiffer, <i>Consultant</i>
Alfred Faber	J. Ernest Breed, <i>Consultant</i>

Samuel Levinson

# medical-legal

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## MEDICAL LEGAL COUNCIL

The Medical Legal Council is responsible for maintaining liaison with the Bar Association, supervising the activities of the Council's three constituent committees, and educating the members of the profession in medico-legal affairs.

Dr. Clinton Compere, Council chairman, sought the direction of the Board of Trustees regarding the responsibilities of the Council in dealing with solutions to the malpractice problem in Illinois. Dr. Compere has received the approval of the Executive Committee to again seek to develop solutions in the area of physician legal ability.

The Chicago Bar Association's Medical-Legal Relations Committee, through its Physician Liaison Subcommittee, has met with the ISMS Medical Legal Council and finalized plans for a Malpractice Seminar for the 1971 ISMS Annual Meeting.

Past problems, with regards to formulating a screening panel for Illinois, have been reviewed by the Council with the Liaison Subcommittee of the Chicago Bar Association. In an effort to reach agreement, the Council requested that the Medical Legal Relations Committee review our past proposals, and bring back for decision a plan considered acceptable by the Chicago Bar Association.

The Committees of the Council are the Impartial Medical Testimony Committee, the Laboratory Services Committee, and the Committee on Licensure. Actions of these committees are reported through the Council to the Board of Trustees for the House of Delegates. This report includes the decisions of the Council and its committees.

### IMPARTIAL MEDICAL TESTIMONY

The IMT program continues to provide valuable service to the Illinois and U.S. District Courts. Since its original implementation in September, 1961, it has been a vital factor in the resolution of over 300 cases. The program has established itself as a device to be used in relatively important or unusual cases, where there is a wide gap in medical testimony. The importance of the program should not be confused with the volume of its use.

Our current panel of examining specialists is being up-dated. Physicians interested in serving on the panel have been contacted and will be appointed shortly. The office of the ISMS controls the lists of panelists and supplies the appropriate specialists in rotation.

Those physicians who serve on the panel have earned the thanks and respect of every member of the ISMS.

### LABORATORY SERVICES

This Committee has devoted its attention to the problems related to the curtailment of state laboratory serv-

ices throughout Illinois, and the Supreme Court ruling of September 29, 1970 declaring blood a product rather than a service.

Curtailment of state laboratory services was necessary because of changes in the state budget. These services are presently available in private laboratories throughout the state and apparently the curtailment has not been interfering with good patient care. Therefore, the Committee feels no need for any action on this matter at this time.

Without question, the most important matter discussed by the Committee during the past year was the ruling of the Illinois Supreme Court regarding the Cunningham vs. MacNeal Memorial Hospital transfusion-hepatitis controversy.

The following recommendations were evolved from the discussion of the Committee.

1. The bill prepared by the Council on Legislation and Public Affairs should address itself to the concept of strict liability, rather than implied warranty, and contain a section declaratory of public policy.
2. An emergency clause should be included.
3. The bill prepared should be a joint effort between ISMS and IHA.
4. ISMS-IHA jointly encourage the recruitment of voluntary donors, especially pre-deposit donors.

The Laboratory Services Committee would like to express its appreciation to the Council on Legislation and Public Affairs, and Dr. James Hartney, for their efforts in preparing legislation and securing the endorsement of several other organizations.

### LICENSURE

The Committee on Licensure has been most active during the past year and has devoted much energy to the consideration of resolutions referred from the House of Delegates for implementation or consideration.

Resolution 70M-1, from the last session of the House of Delegates, urged ISMS to use its resources in seeking to have the Board of Medical Examiners process applications for medical licensure by reciprocity or endorsement on at least a monthly basis when such applications are pending. Dr. Schnepf has informed the Committee on Licensure that the Department of Registration and Education is preparing legislation that would allow a physician licensed in another state to practice in Illinois on his out of state license for a period of six months. During that six month period he would have to satisfy the requirements for licensure in Illinois. The Committee felt this action would accomplish the intent of Resolution 70M-1. The Board of Trustees, upon the request of the Medical Legal Council, accepted in principle the bill to be prepared by the Department of Registration and Education and instructed the Council on Legislation and



Public Affairs to study the amendment and provide appropriate support.

Resolution 70M-2 was referred by the House of Delegates to the Medical Legal Council for consideration. This resolution requested legislation to amend the Medical Practice Act to delete the examination requirement for licensure by reciprocity. The Committee feels such legislation should not be introduced and that the Board of Medical Examiners should retain the philosophy of an examination for reciprocity. The Board of Trustees approved the recommendation of the Medical Legal Council, as reported.

Resolution 70M-29, dealing with professional licensing policies, was referred to the Medical Legal Council by the House of Delegates for further study. The Committee endorsed the intent of this resolution with the following change: that ISMS recommended to the Medical Examining Board rather than the Department of Registration and Education.

The following recommendation was approved by the Board of Trustees:

*That ISMS recommend to the Medical Examining Board that if a doctor is licensed in another state, or has passed a national board examination, or is certified in his specialty, or has been recognized as board eligible, there should be a more realistic appraisal in granting licensure by reciprocity or endorsement, after appropriate inquiries have been made regarding those that apply for licensure.*

The Committee has discussed this resolution with Dr. Schnepf and he assured the members of the Committee that the Medical Examining Board is granting more licenses by eminence. The intent of this resolution is being followed at this time.

Resolution 70M-30, as passed by the House of Delegates, requested that all State Mental Health Facilities offering services that correspond with private psychiatric hospitals be subject to the same minimum standards.

The Committee on Licensure felt legislation would not be needed to accomplish the intent of the resolution. The Board of Trustees approved the recommendation of the Medical Legal Council requesting ISMS to contact the governor and request that the State Mental Health Facilities be required to meet the same minimum standards that private psychiatric facilities are required to meet by the Department of Public Health.

Dr. Albert Glass, director of the Illinois Department of Mental Health, requested that psychiatrists who are board certified be granted licensure in Illinois without examination. Dr. Schnepf pointed out the problems that would be created by allowing psychiatrists licensure on the basis of board certification.

There was no conflict with the position of ISMS as

expressed in resolution 70M-29. However, the Committee felt that since the Medical Examining Committee has eased the standards for licensure by eminence, this would allow Dr. Glass to secure the services of psychiatrists for the Department of Mental Health.

Another request by Dr. Glass was that ISMS consider legislation which would allow physicians presently working in state facilities with a limited license to receive a permanent limited license.

Illinois law presently states that anyone receiving a limited license for the first time after July 1, 1966, may not renew his license more than three times. This gives the physician six years in which to become fully licensed.

The Board of Trustees reaffirmed the previous recommendation of the Committee against the granting of permanent limited licenses in Illinois.

### Medical-Legal Council

Clinton Compere, *Chairman*

Ross Hutchison	George Alvary
David T. Petty	Vincent Sarley
Herman Wing	Joseph Sherrick
Leonard C. Arnold	Edward Quebbemann, <i>SAMA</i>
George Keller, <i>SAMA</i>	
<i>Consultants</i>	
Fredric Lake	Joseph L. Bordenave
Wm. A. McNichols	

### Committee on Impartial Medical Testimony

Vincent Sarley, *Chairman*

Dennis Dorsey	Jerome J. McCullough
Maurice D. Murfin	Ronald Shlensky
<i>Consultants</i>	
Samuel Levinson	Clinton Compere
James B. Hartney	

### Committee on Laboratory Services

Joseph Sherrick, *Chairman*

Ronald Jessen	John J. Mueller
Peter Soto	Hans Willuhn
Jack Williams	James B. Hartney, <i>Consultant</i>

### Committee on Licensure

Ross Hutchison, *Chairman*

Wilson West	Clay Jones
Henry Boldt	Raymond B. Murphy
Morgan Meyer	William T. Davin
<i>Consultants</i>	
Joseph L. Bordenave	Charles K. Wells
Frank J. Jirka, Jr.	

## ETHICAL RELATIONS

As of the time of publication, no cases had been appealed to the Ethical Relations Committee. Should any action be required, a supplement report will be filed for the House of Delegates.

William M. Lees, *Chairman*

James B. Hartney	L. T. Fruin
Fred Z. White	

# mental health and addiction

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## COUNCIL ON MENTAL HEALTH AND ADDICTION

The Council on Mental Health and Addiction, and its two constituent Committees—Alcoholism and Narcotics—have met regularly throughout the year and have been particularly aggressive in their deliberations and actions. A dedicated concern for the health and well being of the public and the profession has been demonstrated by the members of the Council and Committees.

### ALCOHOLISM

The Committee on Alcoholism has been studying various legislative decisions in other states, particularly Maryland, with a view toward formulating items for consideration as part of Illinois statutes. An attempt is being made to suggest legislation which would align our statutes with recent federal legislation. Work in this area is proceeding and cooperation is expected from other health providing agencies. Bills which have already been introduced into the 77th General Assembly may accomplish this and the Committee will recommend action which should be followed to the Council.

Support of the Council was given the Committee in the area of implied consent legislation. Other activities of the Committee on Alcoholism including planning a program for the 1971 annual meeting, and meeting jointly with the ISMS Committee on Public Safety.

### NARCOTICS

Highly involved as a source group for information on Narcotics and Drug Abuse, defines the activities of the Narcotics Committee. Services have been furnished not only to communities but to medically oriented lay and professional groups. For example, the Committee suggested to, and received approval from, the Board of Trustees to co-convene a meeting with the American Medical Association, the Chicago Association of Commerce and Industry, and the Chicago Medical Society to try to serve as a catalyst and bring order out of the many drug abuse programs in the state. The dedication of the chairman of our committee is commendable and we applaud the efforts of his Committee in trying to formulate adequate programs in the field of drug abuse and education.

The Council has been active in numerous areas. Its membership has been complemented by various representatives of other groups: the Department of Mental Health, the Chicago Board of Health, the Chicago Medical Society, the Illinois Psychiatric Society, the Illinois Mental Health Association.

A general booklet is being prepared by the Council and will be distributed, for general information, to all physicians. Its contents relate to rules, procedures and

explanations of the mental health code. The Board of Trustees approved printing funds for this project through unrestricted funds in the Educational and Scientific Foundation.

An ongoing process of legislative review is conducted by the Council on Mental Health. Specific bills are cited to the members of the Council and recommendation is then made to the Board of Trustees for referral to the Council on Legislation and Public Affairs.

Recent bills relating to marihuana and the changing of its definition from a narcotic to a depressant or stimulant drug were reviewed and approved. Those bills not changing this definition were not supported. In addition, the Council felt that all bills must include stricter penalties on those who are pushing or selling narcotics or marihuana.

Possible bills related to changing insurance codes in favor of psychologists, and payment of psychologists' services, were reviewed. This was not supported by the Council. Future guidelines and suggestions were made as a matter of record for the Council so that in the future, should the need arise, guidelines will have been established.

Peer Review has been an ongoing topic of the Council and, in collaboration with the Illinois Psychiatric Society, specific procedures have been established so that Peer Review for psychiatric services will be obtained in cooperation with the Illinois State Medical Society guidelines.

Of great concern to the Council is the confidentiality of records. Recent court cases have required producing medical records of psychiatrists in court. The Council has requested the ISMS Council on Legislation and Public Affairs to introduce legislation firming up the laws regarding the disclosure of information. The physician/patient relationship must be protected.

The attitude of the Council has been progressive and has formed a nucleus for mental health action.

### Council on Mental Health and Addiction

Marshall A. Falk, *Chairman*

John H. McMahan, *Vice-chairman*

Milton C. Baumann

Irving Frank

Richard Graff

Billie H. Shevick

Alex Spadoni

Donovan Wright

David Shapiro, *SAMA*

A. E. Livingston, *Consultant*

Mrs. Michael Parenti, *Auxiliary*

Nathaniel S. Apter

Mark Fields

Abraham Gelperin

Walter P. Plassman

Joseph H. Skom

W. David Steed

S. Dale Loomis

Richard Jacobs, *SAMA*



### **Committee on Alcoholism**

Abraham Gelperin, *Chairman*

Charles L. Anderson	David Stinson
J. M. Stoker	John C. Troxel
James West	William H. Wehrmacher
Mark Larsen, <i>SAMA</i>	

### **Committee on Narcotics**

Joseph H. Skom, *Chairman*

Richard B. Eisenstein	Jerome H. Jaffe
Kermit T. Mehlinger	Harry W. Parks
George Silvest	David Slight
Robert Strauss, <i>SAMA</i>	Wm. A. McNichols, <i>Consultant</i>

## **ILLINOIS DEPARTMENT OF MENTAL HEALTH**

The Illinois Department of Mental Health, carrying the legislated charge of responsibility for the mental health of the citizenry of Illinois, has moved significantly this past year in revising some major fundamental foci, conceptually, operationally, clinically, and administratively.

### **Conceptually**

There now exists sufficient understanding and acceptance of emotional dysfunction to make community-based treatment feasible and desirable, and long-term institutionalization unnecessary. A constantly increasing body of knowledge supports the finding that traditional institutionalization for persons with mental disorders in large distant State facilities not only impedes recovery but generally results in severe dependency and permanent impairment. Furthermore, even short-term institutionalization as the treatment of choice has been shown in repeated studies to result in a high rate of recidivism, and to be more costly financially. While it is recognized that small numbers of severely handicapped, mentally ill and mentally retarded persons will continue to need our long-term institutional care, separation from home, family, and community are no longer justifiable for lesser psychiatric dysfunctioning.

The current IDMH thrust then is threefold: (1) prompt intervention at the earliest point possible in the interest of prevention; (2) treatment techniques applied in the patient's own community and simulating his "natural" environment insofar as is possible; and (3) greater encouragement by DMH staff on all regional levels for each community to become actively involved in the establishment of community-based facilities.

### **Operationally and Clinically**

Current objectives revolve around changing a predominantly State-operated institutional system of mental health care to a mainly community-based network of mental health services supported by State regional facilities for the more severe types of mental illness and retardation.

State hospitals are expected to continue upgrading both in physical facilities and personnel-patient ratio. Resident patient population has decreased, in part due to revised philosophy stressing movement out of the institutions and return to the community of origin, and due to expansion of community-based services which have intercepted, thereby decreasing admissions to state mental hospitals.

Utilizing all personal and community resources calls for linkage with public and private welfare agencies, medical surgical facilities, vocational and rehabilitative agencies,

and consultation and education as indicated.

Currently, some of the Department's prime operational programs are rendering special services to drug abusers; alcoholics; mentally disturbed geriatric patients; children and adolescents; mental retardates; and the medically indigent in need of psychiatric help.

### **Drug Abuse Program**

The Illinois Drug Abuse Program, established in 1968, jointly with the University of Chicago Pritzker School of Medicine, has achieved national prominence, especially in the treatment of heroin addiction under the methadone program. Because of the necessity for centralized control, narcotic drug abuse programs have not been decentralized to the Zones as have most other DMH programs.

A consistent and major feature has been the actively sought involvement of community organizations in assuming responsibility for the drug abuse programs, e.g., Gateway House. When these organizations come into operation and integrate with the central intake and control procedures, they are supported by purchase-of-care funds.

More recently, programs for non-narcotic drug abusers of marijuana, barbituates, amphetamines, and psychedelic drugs have been initiated by the Department of Mental Health and State assisted community organizations. It is interesting to note that these drug abusers often involve younger age groups from suburban areas.

### **Children and Adolescents**

Major focus is being placed upon the important mental health needs of children and adolescents. Residential treatment units for children (under 13) and adolescents (13-17) have been present in all Zone Centers and seven State hospitals. The Adler Zone Center in Champaign (Zone 6) on the grounds of the University of Illinois, and which is operated exclusively for children, engages in pilot and special programs exploring new treatment modalities.

Recognizing that all children—disturbed, retarded, as well as "normal"—have a right to such generic services as education, maintenance, and guardianship, each Zone is engaged in providing treatment for all behaviorally dysfunctioning and mentally retarded children in its area. This includes special educational and rehabilitative services which maximize growth and development, and potential for return to the community.

### **Mental Retardation**

The Illinois Department of Mental Health has worked regionally through its Zones and their assistant directors for mental retardation in both directions operant at this point in time, i.e., delivering direct services, along with developing community responsibility. While continuing to support state-operated intermediate residential treatment facilities and the extended care residential facilities (Dixon, Lincoln, Murray, Fox, and Bowen State Schools for the retarded), the recent Departmental thrust has been, in the direction of encouraging more and more community responsibility for the development of community services for the retarded. These include day treatment and sheltered workshops, as well as residential living facilities for adult retardates.

Other major facets of the Department's Mental Retardation Program include elimination of the emergency waiting list, construction of seven new 400-bed mental retardation facilities in the Chicago Area Zone, depopula-

tion of the large Lincoln and Dixon State Schools by transfer of suitable adult retarded to appropriate unused facilities at State mental hospitals, and placement in special facilities at Aurora for less severe adult retardates with demonstrable potential for social and vocational rehabilitation.

#### **Title XIX (Medicaid)**

The Emergency Psychiatric Treatment Program for Medically Indigent Persons, initiated late in 1968, and financed by State legislative appropriations, is now being augmented and superseded by the Title XIX Program (Medicaid) which expands the medical-surgical services for Public Assistance recipients to include mental disorders, through federal matching funds.

For the first time, community psychiatric services are available to all those eligible for Medicaid benefits including all Public Assistance recipients. This program announced in January and now in the process of implementation, is administered by the Department of Mental Health, which must determine and approve the providers of psychiatric services in the private sector, entering into written agreement with each provider. The latter may be either public or private, but the services must be provided in an approved medical setting.

#### **Administratively**

The year, 1970, saw such managerial inaugurations as the Position Inventory Reporting System; implementation of a unique Operant Research Division; and now in its embryonic state, the Management Cost System.

The Operations Research Division serves to coordinate and make smooth the interrelated functioning of all of the DMH's components, Divisions, all patient programs, and all research, both basic and applied.

The Operations Research Division comprises four sections: (1) Clinical/Medical applications; (2) Management applications; (3) Systems analysis; and (4) Mathematical modeling. Material that is system-wide in its implications receives the combined effort of the four sections in addition to extra-systemic input when and as indicated. Supplementing intuitive judgment with quantitative analysis, the Operations Research Division serves in total Departmental functioning, emphasizing overall performance, clarifying goals and solutions.

Management Cost System, pegged for pilot implementation in 1971, has two basic elements, each designed with specific capabilities:

1. A cost accounting element designed to provide the advantage of direct patient billing (outpatient and inpatient), third party payment procedures as applicable, and maximally efficient financial reporting and record keeping; and
2. a patient treatment element, capable of monitoring patient care program objectives, with built-in indicators designed to assure maximal total patient care.

Such a cost accounting system, supplying cost-benefit data, will allow more factual analysis of the Department's programs. The financial management system is expected to become operational in the Department's many institutions within the next few years. The pilot project is scheduled for mid-1971.

Albert J. Glass, M.D., *Acting Director*

## **Visit your Exhibits Open 9 - 5 p.m. daily Arlington Park Towers**

Technical Exhibits    Jimmy Durante Ballroom  
Scientific Exhibits    House of Delegates Corridor  
Medical Self-Testing  
                                Round Table 1—Lower Level  
Physicians' Art            Jimmy Durante Corridor



# public relations and membership services

## COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

During the past year, the Council has participated in important new projects designed to help solve major health problems facing the medical profession.

In keeping with major ISMS organizational changes, these programs have been the result of a new spirit of coordination and cooperation between councils, committees, and staff.

During the 1971 session of the Illinois Legislature, a series of Health Legislation Background Reports was developed for four major TV stations—Peoria, Rock Island, Quincy and Rockford. Jointly planned by this Council and the Council on Legislation and Public Affairs, the weekly three-minute segments furnished thousands of Downstate TV viewers with up-to-the-minute information on current health legislation. In addition to receiving credit for making the impartial news reports available, ISMS was able to make valuable new contacts with state legislators. Cost of the 17-week project, \$3,400, was shared by the Councils on Public Relations and Legislation.

### Field Program

The Council also supported the revised ISMS Field Program aimed at strengthening ties with county medical societies. A Blood-Hepatitis Campaign, with news releases and other materials furnished by our Council, was offered to 11 major county societies which do not have executive administrators.

These counties, utilizing background kits and liaison furnished by Philip Thomsen II, ISMS field representative, provided effective grass-roots support for the ISMS campaign to enact legislation exempting blood and other human tissue from strict doctrines of implied liability.

The Council also participated in the development of a slide presentation on the highlights of the 1971 ISMS Annual Meeting at Arlington Park Towers Hotel. This slide presentation was shown to numerous county medical societies and several district meetings. Another slide presentation on the hazards of chiropractic was developed for use by the ISMS Auxiliary.

### Membership Survey

A major Council project for next year will be the third biennial ISMS Membership Survey on Socio-Economic Issues. The results of this survey will help determine new directions and projects for our Society during 1971 and 1972.

While participating in cooperative ventures to enhance our society's drive toward more active leadership in vital health issues of the day, the Council has not neglected our traditional health education programs. For instance:

- Dr. SIMS health columns have been updated and are now carried in more than 415 school newspapers; a record number.
- The Dr. SIMS health tips for Illinois radio stations were completely revised and updated, and the new format is now being carried by 82 stations—again a record number.
- In addition, 37 daily newspapers in Illinois now use Dr. SIMS health tips.

The ISMS New Membership Packet was completely updated and redesigned. More than 220 of the packets were distributed to every county medical society.

During Community Health Week, in October, 1971, a four-part newspaper series by our President, Dr. J. Ernest Breed, was carried by more than 20 Illinois newspapers.

### Medicare Fact Sheet

Another project, a *Medicare Fact Sheet*, enjoyed a remarkable distribution. The fact sheet, headlined "Now Read the Truth About Medical Costs," was distributed by physicians to more than 220,000 patients, most of them in Illinois. Samples of the fact sheet were requested from physicians and medical organizations across the country, and one state—Arkansas—reprinted the fact sheet for its own state society. The fact sheet also earned feature articles in *Medical World News*, the *AMA News* and other publications. The Board of Trustees has authorized a second fact sheet for distribution this summer.

The Council's annual Medical Journalism Awards Contest attracted entries from more than 200 newspapers and radio and TV stations across Illinois. On March 13, 21 award winners were honored at the Ambassador West Hotel in Chicago, during the Journalism Awards Banquet.

The Council would like to single out for recognition, the Medicine and Religion Seminar in Rock Island on February 10. Our Committee on Medicine and Religion and the Rock Island County Medical Society jointly developed the seminar. The one-day program attracted more than 175 physicians and clergy from the Rock Island area. Numerous news reports appeared in Rock Island area newspapers, radio and TV stations, as well as a feature story in a Chicago newspaper.

Matthew B. Eisele, *Chairman*

Lee F. Winkler  
Clifton Reeder

Anna A. Marcus  
Charles J. Weigel

M. Douglas Hursh  
*Consultants*

Paul W. Sunderland  
Henry Covelli, *SAMA*

Fredric D. Lake  
Roger Rodgers, *SAMA*

L. T. Fruin  
Mrs. Leslie Lindeen, *Auxiliary*



## INSURANCE

In addition to overseeing insurance, investment and retirement programs currently sponsored by the Society, the Committee has received a number of requests to consider new programs. Current programs include:

### Disability:

The annual report of the Administrator shows this program to be sound and functioning as expected. A few complaints from members have been received and almost every one has been settled to the satisfaction of the members.

### Major Medical:

Claims are increasing somewhat faster than anticipated. The Administrator has indicated that the carrier may ask for a rate increase in 1971. This will be evaluated when and if received.

### Professional Liability:

This program is also progressing satisfactorily. The increasing enrollment each year is about what was predicted. Total claim payments have been small but the dollar amount of suits filed is high. There is no relationship between the dollar amount of suits or threatened suits and the amount that might eventually be paid. There are about 2,500 presently enrolled.

### Retirement & Investment:

The Administrator has asked permission to use a load fund for investing new money rather than a no-load fund. This matter is under consideration. A decision has not been reached.

### New Programs

New programs that have been presented to the Committee for review and possible adoption:

### Hospital Income Plan:

This is a supplemental coverage that would pay either \$20 or \$40 per day for each hospital inpatient day. Members, members' staffs and families are eligible. Considering the high cost of hospitalization, this program appears to have merit. Two potential administrators have presented two programs, each somewhat different. The Committee is presently studying both of them.

### Business Expense Insurance:

This type of insurance is disability insurance at somewhat less cost because it covers only the office overhead, aides, rent, etc., for a limited period, usually one year. The doctor must be disabled and he can collect only for his out-of-pocket expenses as long as he maintains his office. The Committee is studying this.

### Life Insurance:

Several programs have been filed for members, members' staff and families. These are under consideration.

### Retirement and Investment Program:

This is considerably different from the one currently approved by the Society. The Committee is now awaiting explanation of many details before further consideration.

In summary, the main activities of the Committee are to supervise the programs currently sponsored, to be sure the members are treated fairly, and to evaluate and make recommendations on any new programs presented to the Committee.

Clifton L. Reeder, *Chairman*

Philip D. Boren  
James B. Flanagan

A. Everett Joslyn  
Lawrence Knox

*Consultants*

A. Edward Livingston    Jacob E. Reisch    Fred Z. White

## MEDICINE & RELIGION

The Committee is pleased to report a successful year in its goal of reinforcing in the minds of Illinois physicians and clergy the importance of faith as part of the healing process.

A highlight of this year's activities was the Medicine and Religion Seminar held in Rock Island on February 10. Developed and co-sponsored by the Rock Island County Medical Society, the seminar attracted more than 175 participants from the clergy as well as physicians in the Rock Island area. Attendance at the morning session on abortion totaled more than 175 persons, with 100 participants remaining for lunch and the afternoon discussion program on "Death and Dying."

The Committee also developed a Medicine and Religion Seminar for the Annual Meeting program. On Monday, May 17, Dr. William B. Walsh, founder and president of Project HOPE, will headline a program on "Faith and Reason in Healing." An afternoon session will be devoted to a medicine and religion workshop.

Another Annual Meeting feature will be a Medicine and Religion Exhibit, and a Medicine and Religion Awards program. County medicine and religion committee chairmen will assist in manning the exhibit booth. The medicine and religion awards—one to a physician and one to a clergyman—will be presented just prior to

the seminar on Monday, May 17.

The Committee helped develop a series of one-day Medicine-Religion Postgraduate Seminars at Loyola University, to be held in cooperation with the American Medical Association. The first one-day seminar is tentatively scheduled for the first week-end after Labor Day. The seminars will be aimed toward private practitioners, parish clergy, and seminary and medical school students.

The Committee is pleased to report that 17 county medical societies now have Medicine and Religion Committees. We also assisted the Adams County Medical Society in forming a new Medicine and Religion Committee.

The Committee assisted in formulation of ISMS policy statements in relation to legal decisions on abortions in Illinois this year.

Anna A. Marcus, *Chairman*

William B. Rich  
William H. Whiting  
Clement P. Cunningham

David J. Kweder  
Charles W. Pfister  
Warren Young

*Consultants*

Rabbi Mordecai Simon

Father John Marren

Reverend Herman Cook

Mrs. Sherman C. Arnold, *Auxiliary*



# social and medical services

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## COUNCIL ON SOCIAL AND MEDICAL SERVICES

The Council on Social and Medical Services participated in several important activities during the past year.

At the direction of the Board of Trustees, the Council, with the help of Edward W. Cannady, M.D., trustee-at-large, exerted leadership in unifying representation and leadership of home health care agencies and services in the state.

On February 18, in Springfield, Dr. Cannady and the representatives of more than 12 home health care agencies held a preliminary meeting to determine the feasibility of establishing a cohesive group to unify and strengthen nursing and homemaking programs.

Since the Illinois Council of Home Health Services already exists, it was proposed that this council expand membership and responsibilities to encompass all home health care agencies in the state, avoiding creation of a second council. A steering committee was formed to implement this proposal. Pursuant to instructions from the Board of Trustees, the role of ISMS will be limited to that of a consultant, with control left to the agencies involved.

Because there are more than 60 home health care agencies in Illinois, and recognizing the importance of follow-up home health services in overall patient care, the unification of home health agencies is a step of major significance to Illinois physicians.

The Council also studied a new type of private health care program under which an organization contracts to provide emergency health services. A specific example is Physicians on Call, a Lombard firm, which places physicians, interns and residents in some hospital emergency rooms, and staffs clinics in smaller communities which lack family physicians.

Questions and problems posed by the operation of such firms include the lack of liaison between the firm and county medical societies, and, in some cases, hospital medical staffs; quality and cost of care provided; determination of credentials of physicians employed by such firms; and circumvention of normal peer review procedures when such firms contract directly with hospital administrators or unmanned medical clinics.

The Council, at the direction of the Board of Trustees, is drawing up a set of guidelines for establishing liaison, and retaining some medical control, over such firms. Particular emphasis will be given to determining quality and costs of care afforded, and methods of confirming licensing and credentials of physicians employed by such firms. The guidelines will be distributed to county medical society and hospital medical staffs for use at their discretion.

The Council has also considered the proposed establishment of the Illinois Registry of Medical Transcribers.

Such a registry would be better established under the umbrella of the Illinois Medical Assistant's Association, an existing agency which has the support of ISMS. Negotiations are underway to effect this recommendation.

The Council has lent advice and support to various projects detailed in the committee reports which follow.

## AGING

A major project of the Committee has been making preparations for the White House Conference on Aging scheduled for November 28, 1971, in Washington, D.C.

The Board of Trustees concurred in Committee recommendations for ISMS nominees for appointment to the Illinois delegation to the White House Conference, as well as nominees for appointment to the new Illinois Committee for Senior Citizens, a special committee appointed by Governor Ogilvie.

The Board also approved a committee recommendation to devote the November, 1971, issue of the *Illinois Medical Journal* to geriatrics. A downstate Seminar on Aging, originally scheduled for January 28, 1971, in Springfield, was cancelled because of insufficient advance registration.

Rather than schedule another seminar, it was decided that a special issue of *IMJ* would reach a wider professional—and public—audience. The Public Relations Division will assist by furnishing news articles and promotional pieces for distribution to professional publications and news media in Illinois. President Nixon's White House Conference on Aging in November will lend added impact to the program.

The Committee was also concerned with such problems as retroactive denial of benefits under the nursing home benefits portion of Medicare. In an effort to clear up misunderstandings, and to try and improve Medicare coverage for patients, the committee invited representatives of a major third party carrier to a committee meeting. The resulting discussion was very rewarding and a report based on this discussion will appear in a forthcoming issue of the *IMJ*. The Committee also hopes to make increased utilization of the 13-part pre-retirement film series, "The Time of Your Life."

## REHABILITATION SERVICES

During the past year, the Committee completed a detailed study of a proposed act to license and regulate physical therapy assistants in Illinois. In keeping with the AMA and AHA proposals for a moratorium on licensing of allied health occupations, the Board of Trustees concurred in recommendations to certify, but not license, physical therapy assistants in Illinois.

The Committee also studied problems under Medicare.

Cutbacks in federal funding have resulted in denial of Medicare claims under the physical therapy coverage, even though patients concerned qualify under the letter of the law. These problems will be an area of major concern to the Committee in the coming year.

Possible overutilization of services under the Illinois Division of Vocational Rehabilitation program came to the attention of the Committee since physical rehabilitation and DVR services overlap in many areas. This information was passed on to the ISMS Advisory Committee to DVR.

Other Committee projects included distribution of *Guidelines to Physicians When Prescribing Physical Therapy Services*, and a study of state laws eliminating architectural barriers for handicapped citizens.

**NURSING**

A major project of the Committee during the past year has been organizing a one-day conference to help improve communications between the nursing and medical professions in Illinois. The purpose of the conference, which will be held in the fall, is to achieve further cooperation between the two professions, and to discuss recent developments in nursing education.

The Committee also studied legislation to certify physicians' assistants in Illinois, and made recommendations for those portions of the bill related to registered nurses. This information was given to the Committee on Allied Health Education which investigated the training and certification of physicians' assistants in Illinois and implications for the medical profession.

**Council Membership**

Thomas R. Harwood, *Chairman*

Julian Buser	Joel D. Rosen
Kenneth A. Hurst	William A. Hutchison
Thomas Tourlentes	Paul Theobald
L. T. Fruin, <i>Consultant</i>	Ned Bartlett, <i>SAMA</i>

**Committee on Aging**

Thomas T. Tourlentes, *Chairman*

W. W. Bowers	James R. Durham
Bertram Moss	Clyde Rulison
A. E. Livingston, <i>Consultant</i>	

**Committee on Rehabilitation Services**

Joel D. Rosen, *Chairman*

John E. Finch	James C. Reid
John G. Meyer	Joseph L. Koczur
Frank B. Kelly, Jr.	Arthur Rodriguez
<i>Consultants</i>	
Frank J. Jirka, Jr.	Charles K. Wells

**Committee on Nursing**

William A. Hutchison, *Chairman*

David M. Greeley	Jaroslav F. Neskodny
J. J. Kolb	Roger Sondag
<i>Consultants</i>	
Helen Grace, R.N., Ph.D.	Joyce Taylor, R.N.
Mrs. Thomas Glatter, <i>Auxiliary</i>	

To Reach Us By . . .

**Car**

From the south or southeast (including O'Hare), take the Northwest Tollway (I-90) toward Arlington Heights. Exit at 53 north and take 53 for two miles. Exit at Euclid East and you're there.

From the north take any major highway south to Palatine Road. Take Palatine Road to Highway 53. Take Highway 53 South, and exit at Euclid East.

From the west, take the Northwest Tollway (I-90) toward Arlington Heights. Exit at 53 North and take 53 for two miles. Exit at Euclid East.

From the east, take Lake Avenue west, which becomes Euclid Avenue and leads directly to the hotel.

**Plane**

When arriving at O'Hare, go to American Terminal (lower level) and every 1/2 hour a bright orange and white ARLINGTON PARK TOWERS Courtesy Bus will pick up passengers.

**Bus**

Leave Palmer House (State Street Door)	Leave U. of Illinois Medical Center (818 S. Wolcott)	Leave Arlington Park Towers*
7:30 a.m.	7:45 a.m.	8:45 a.m.
8:15 a.m.	8:30 a.m.	9:30 a.m.
9:00 a.m.	9:15 a.m.	10:15 a.m.
10:00 a.m.	10:15 a.m.	11:00 a.m.
10:45 a.m.	11:00 a.m.	11:45 a.m.
11:15 a.m.	11:30 a.m.	12:30 p.m.
12:00 p.m.	12:15 p.m.	2:00 p.m.
12:45 p.m.	1:00 p.m.	2:45 p.m.
1:30 p.m.	1:45 p.m.	3:30 p.m.
3:00 p.m.	3:15 p.m.	4:00 p.m.
3:45 p.m.	4:00 p.m.	5:00 p.m.

\*Bus from Arlington Park Towers will make stop at medical center, if requested.



# Resolutions

## Resolution 71M-1

Introduced by: Rock Island County Medical Society  
Subject: Revision of Illinois Relative Value Study

WHEREAS the Illinois State Medical Society has adopted a Relative Value Study as official policy of the Society, and

WHEREAS the ISMS policy manual, duly adopted by the House of Delegates, states that "the study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees," and

WHEREAS the Executive Committee and the Board of Trustees have abdicated their responsibility by simply recommending use of the California Relative Value Study, and

WHEREAS, the continuing requests for copies of the study demonstrates that individual members and county societies consider it a valuable guide, and

WHEREAS, values may vary from region to region just as do the customs of medical practice, and

WHEREAS, Illinois physicians seeking to effect changes in keeping with ILLINOIS customs would have to take the manifestly absurd step of requesting California committees to take into consideration Illinois customs when updating their relative value study, therefore, be it

RESOLVED that the Illinois State Medical Society direct its Board of Trustees to comply with its policy manual and to order forthwith a revision of the Illinois Relative Value Study, and be it further

RESOLVED that the revised study be sold to interested parties, if necessary, to defray the cost.

## Resolution 71M-2

Introduced by: Michael Youssi, Student American Medical Association

Subject: Expansion of MECO Project

Referred to: Reference Committee on Education and Community Health

WHEREAS, the Medical Education and Community Orientation (MECO) Project was begun in 1969, as a co-operative effort of the Student American Medical Association, the Illinois State Medical Society, the Illinois Hospital Association, and the Illinois Academy of General Practice, and

WHEREAS, the MECO Project has expanded into a nationwide project with Illinois as the model, and

WHEREAS, the House of Delegates of the AMA recently voted its strong support of the MECO concept, and

WHEREAS, the functional basis of the MECO Project is the organization and support provided in each state, and

WHEREAS, the evaluation of the MECO Project has demonstrated its success as viewed by students, physicians and communities, and

WHEREAS, the response of over two-thirds of the student participants expressing a desire to return to the community to practice demonstrates the long-range potential of MECO as one practical solution to the problem of physician distribution, therefore, be it

RESOLVED, that the Illinois State Medical Society, endorse the MECO Project as a valuable educational program for students, physicians, and communities, and be it further

RESOLVED, that the ISMS Board of Trustees be requested to solicit increased physician participation in MECO in their individual districts, and be it further

RESOLVED, that the development of MECO and similar long-term educational programs involving students and practicing physicians be considered a high priority, and be it further

RESOLVED, that the ISMS continue its leadership in this area by requesting the Task Force on Physician Shortage and the SAMA Advisory Committee to develop new long-range programs to augment and expand the MECO concept.

## Resolution 71M-3

Introduced by: Michael Youssi, Student American Medical Association

Subject: Expansion of MECO Project

Referred to: Reference Committee on Education and Community Health

WHEREAS, two of the main purposes of the AMA Education and Research Foundation are "to provide or aid in the providing of financial aid to recognized schools or institutions of medical education," and "to provide or aid in the providing of financial assistance to students in public or private medical schools," and

WHEREAS, the Foundation has promised to "adapt itself to changing conditions, developing new programs as needed. . . ." and

WHEREAS, the AMA House of Delegates, at its 1970 Clinical meeting, voted to "strongly support the principle of the SAMA-MECO Project as an adjunct to undergraduate medical education," and

WHEREAS, the SAMA-MECO Project utilizes practicing physicians in community hospitals and group practice clinics as "institutions of medical education" and provides valuable financial assistance to medical students, and

WHEREAS, financial basis of the SAMA-MECO Project lies with practicing physicians and community hospitals, with a developmental administrative grant from the Sears Roebuck Foundation, therefore, be it

RESOLVED that the ISMS House of Delegates, declares that the SAMA-MECO Project is worthy of support within the context and purposes of the AMA Education and Research Foundation, and be it further

RESOLVED, that the Illinois House of Delegates requests the Board of Directors of the AMA-ERF to investigate the feasibility of providing financial aid for the continuation and coordination of the SAMA-MECO Project.

## Resolution 71M-4

Introduced by: Wayne County Medical Society

Subject: Need for Control of the Imbalance Among Different Medical Specialties

Referred to: Reference Committee on Education and Community Health

WHEREAS, the supply of certain residencies and residents and the demand for certain residencies and residents are not in balance and

WHEREAS, this imbalance between supply and demand is not being closed at a rate which would tend to close the gap within the foreseeable future and

WHEREAS, the people who control residencies are not anxious to talk about change and

WHEREAS, there seems to be a status ranking for hospitals and hospital superintendents which is directly related to the number of medical education directors and residents employed, the length of residencies, and how much an adjacent community can be provided with ambulatory medical care by the house staff, and

WHEREAS, house staff programs in our nation's hospitals cost 450 million dollars per year and

WHEREAS, many of the 35,000 to 40,000 of our medical and surgical residents may be wasting their time, needlessly standing in line waiting for a senior residency for one, two or three years too long and

WHEREAS, some young residents are not prepared to care for illness at all levels of their specialty and

WHEREAS, each specialty should have a training program tailored to suit its individual needs and

WHEREAS, the present in-hospital training is too long and some ambulatory care training in the private practice sector is desirable and necessary and

WHEREAS, some specialties could be trained almost entirely out of the hospital and

WHEREAS, general surgery which is already in oversupply, constitutes 10% of the practicing physicians and 15% of the residents, therefore be it

RESOLVED, that this House of Delegates urges all hospital administrators and directors of medical education in hospitals having internship or residency programs in the State of Illinois to take into consideration not only the requirements of their hospital but also the supply and demand situation for specialists, nationally, in con-

sidering the number of residents trained in their institution and also be it

RESOLVED, that this House instruct the Illinois Delegates to the American Medical Association to urge the A.M.A. to study this problem and make recommendations to all U.S. medical schools and hospitals involved in medical education on an under-graduate and a post-graduate level and distribute copies of the recommendations to all medical students in the United States.

### Resolution 71M-5

Introduced by: Charles J. Weigel, M.D., for the Council on Public Relations and Membership Services

Subject: Community Health Week

Referred to: Reference Committee on Public Relations

WHEREAS, the Illinois State Medical Society participates in an American Medical Association program called "Community Health Week" in October of each year, and

WHEREAS, the Council on Public Relations and Membership Services believes that much of the impact of that promotional activity is lost because the news media are concerned with state and national elections about that time, and

WHEREAS, the council believes coverage by the news media would be better if "Community Health Week" were held in the Spring, now therefore, be it

RESOLVED, that the delegates to the AMA introduce a resolution recommending that "Community Health Week" be held in the Spring of each year, and that this resolution be introduced at the next annual meeting of the AMA in June, 1971.

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## Late Report:

### Trustees of the Third District

During the year the branches were visited and actions of the House of Delegates and Board of Trustees of Illinois State Medical Society were both reported and explained. In addition reports of Trustees Meetings were reported in detail to the Council of the Chicago Medical Society.

Since a President's Tour is difficult in the Third District, arrangements were made for a combined meeting of the Jackson Park, South Side and Calumet Branches on the subject of Peer Review. Dr. Jirka participated on the panel program arranged by ISMS.

Legislative information representatives on some sixty hospital staffs were supplied with information on a continuing basis concerning both state and national pro-

posals. A great deal of interest has been created according to reports from medical staffs.

During 1970, the Third District produced 213 regular members and 78 resident members for the Illinois State Medical Society. Trustee Fredric Lake was elected Chairman of the Council of Chicago Medical Society.

The Third District Trustees kept aware of the details involved in planning and executing the 27th Annual Midwest Clinical Conference of the Chicago Medical Society. Such information will be helpful as we look forward to a combined ISMS-CMS meeting in 1972.

The Third District has established an active Peer Review Committee with Subcommittees on Prepayment Programs and Grievances, and is studying the feasibility of establishing medical care foundations.



# Program Summary by Days

## Saturday, May 15

8:00 a.m.	Registration of officers and delegates
8:30 a.m.	Seminar in Medical Writing
9:00 a.m.	Credentials Committee
10:00 a.m.	House of Delegates (Special Session)
12 noon	Special Reference Committee No. 1
2:00 p.m.	Board of Trustees Meeting
6:00 p.m.	Board of Trustees Dinner
6:00 p.m.	Past Presidents' Dinner

Jimmy Durante Lobby  
Rooms 134, 136 & Nashua  
Parlors 4 & 5  
Parlors 4 & 5  
Biff Room  
Discovery Room  
Equipoise Whirlaway

## Sunday, May 16

8:00 a.m.	AMA Delegation Breakfast
9:00 a.m.	Registration of Officers and Delegates
10:00 a.m.	District Meetings
	1st District
	2nd District
	3rd District
	4th District
	5th District
	6th District
	7th District
	8th District
	9th District
	10th District
	11th District
12 noon	Rules & Order of Business Committee Luncheon
2:00 p.m.	Credentials Committee
3:00 p.m.	House of Delegates
5:30 p.m.	Delegates Buffet
6:00 p.m.	Illinois OB-GYN Society Board Dinner
7:00 p.m.	Reference Committees
	Officers & Administration
	Finances, Budgets & Publications
	Constitution & Bylaws
	Economics & Medical Service
	Legislation & Public Affairs
	Education & Community Health
	Public Relations & Miscellaneous Business
	Special Reference Committee No. 2

Equipoise-Whirlaway  
Jimmy Durante Lobby

War Admiral  
Room 136  
Swaps Room  
Nashua Room  
Room 130  
Room 138  
Room 114  
Room 104  
Top of the Towers  
Room 134  
Sea Biscuit  
Room 100

Parlors 4 & 5  
War Admiral & Sea Biscuit  
Top of the Towers

Rainbow Room  
Equipoise-Whirlaway  
Nashua Room  
Citation Room  
Discovery Room  
Swaps Room  
Room 130  
Room 104

## Monday, May 17

8:00 a.m.	Registration
8:00 a.m.	Board of Trustees Breakfast
8:00 a.m.	Illinois Surgical Society
8:00 a.m.	Central Illinois Medical Association Breakfast
8:30 a.m.	Instructional Courses
9:00 a.m.	Exhibits Open
10:00 a.m.	Illinois Obstetrical & Gynecological Society
10:30 a.m.	Medical Malpractice Seminar
10:30 a.m.	Diabetes Project
10:30 a.m.	Medicine & Religion Seminar
1:30 p.m.	Illinois Obstetrical & Gynecological Society
1:30 p.m.	Today's Youth
1:30 p.m.	Illinois Surgical Society
4:15 p.m.	IMPAC Annual Meeting
5:00 p.m.	Exhibits Close
6:00 p.m.	Public Affairs Reception & Dinner

Jimmy Durante Lobby  
Sea Biscuit  
Cook County Hospital  
Room 104

Jimmy Durante Room  
Discovery Room  
Swaps Room  
Nashua Room  
Equipoise-Whirlaway  
Discovery Room  
Citation Room  
Swaps Room  
Sea Biscuit  
Jimmy Durante Room  
Parlors 4 & 5

## Tuesday, May 18

8:00 a.m.	Registration
8:00 a.m.	Central Illinois Medical Association Breakfast
8:00 a.m.	Board of Trustees Breakfast
8:30 a.m.	Instructional Courses
9:00 a.m.	Exhibits Open
9:00 a.m.	Allergy Program
10:30 a.m.	Diabetes Project
10:30 a.m.	The Depressed Patient
12 noon	Fifty Year Club Luncheon
12 noon	Illinois Academy of Preventive Medicine Luncheon
1:30 p.m.	Radiology Program
1:30 p.m.	Physician Assistants Program
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
2:00 p.m.	Cancer Symposium
2:00 p.m.	University of Illinois Alumni
5:00 p.m.	Exhibits Close
6:00 p.m.	Pathology Dinner
6:00 p.m.	President's Banquet & University of Illinois Alumni Dinner

Jimmy Durante Lobby  
Room 104  
Sea Biscuit

Jimmy Durante Room  
Discovery Room  
Nashua Room  
Swaps Room  
Equipoise-Whirlaway  
Sea Biscuit  
War Admiral  
Swaps Room

Parlors 4 & 5  
Citation Room  
Discovery Room  
Jimmy Durante Room  
Room 104  
Parlors 4 & 5

## Wednesday, May 18

8:00 a.m.	Registration
8:00 a.m.	Board of Trustees Breakfast
8:00 a.m.	Central Illinois Medical Association Breakfast
8:30 a.m.	Instructional Courses
9:00 a.m.	Exhibits Open
9:30 a.m.	Credentials Committee
10:00 a.m.	House of Delegates
10:15 a.m.	Pediatrics Program
10:30 a.m.	Diabetes Project
12 noon	Family Physicians Luncheon
12:15 p.m.	Pediatrics Luncheon
1:30 p.m.	Emergency Room Problems & Procedures
1:30 p.m.	Human Sexuality
5:00 p.m.	Exhibits Close
5:30 p.m.	Loyola University Alumni
6:00 p.m.	Board of Trustees Dinner

Jimmy Durante Lobby  
Sea Biscuit  
Room 104

Jimmy Durante Room

Parlors 4 & 5  
War Admiral  
Nashua Room  
Discovery Room  
Sea Biscuit  
Swaps Room  
Citation Room  
Jimmy Durante Room  
Paramount Ballroom  
Discovery Room

### HOUSE OF DELEGATES MEETING

Saturday, May 15 .....	10:00 a.m.
Sunday, May 16 .....	3:00 p.m.
Tuesday, May 18 .....	2:00 p.m.
Wednesday, May 19 .....	10:00 a.m.

### REFERENCE COMMITTEE MEETINGS

Saturday, May 15	Special Reference Committee No. 1 .....	12 noon
Sunday, May 16 .....		Biff Room
		7:00 p.m.

Officers and Administration .....	Rainbow Room
Constitution and By-Laws .....	Nashua Room
Finances, Budgets and Publications .....	Equipoise-Whirlaway
Economics and Social Services .....	Citation Room
Legislation and Public Affairs .....	Discovery Room
Public Relations and Miscellaneous Business .....	Room 130
Education & Community Health Services .....	Swaps Room
Special Reference Committee No. 2 .....	Room 104

### BOARD OF TRUSTEES MEETING

Saturday, May 15	2:00 p.m.	Discovery Room
Monday, May 17	8:00 a.m.	Sea Biscuit
Tuesday, May 18	8:00 a.m.	Sea Biscuit
Wednesday, May 19	8:00 a.m.	Sea Biscuit
Wednesday, May 19	6:00 p.m.	Discovery Room

Instructional Courses eligible for additional credit on hour-for-hour basis.  
Instructional Courses also approved for credit toward AMA Physician Recognition Award.  
Program is acceptable for 24 elective hours by the American Academy of General Practice.



# Convention Program by Subject

## SEMINAR IN MEDICAL WRITING

Presented by  
American Medical Writers Association  
Robert E. Dunbar, President  
Greater Chicago Chapter

Saturday, May 15

Rooms 134, 136 and  
Nashua

9 a.m.

All-day seminar consists of 3 workshops to be conducted by Charles Roland, M.D., Chairman, Department of Biomedical Communications, Mayo Clinic, Rochester, Minn.; Lester King, M.D., Senior Editor, *Journal of the American Medical Association*, Chicago, and Guy Whitehead, Ph.D., Editor, Publications Section, Mayo Clinic.

## ILLINOIS SURGICAL SOCIETY

William Requarth, M.D., President & Chairman  
Frank A. Folk, M.D., Secretary  
Frank C. Spencer, M.D., Guest Speaker

Monday May 17 Cook County Hospital  
8:00 a.m. Surgical Clinics, Main Operating Room;  
7th Floor

### Colon Surgery

SURGEON: Peter Rosi, M.D., Professor of Surgery, University of Illinois, College of Medicine.  
MODERATOR: Francis Banich, M.D., Assistant Clinical Professor, Loyola University Stritch School of Medicine, Attending Surgeon, Cook County Hospital

### Chest Surgery

SURGEON: Walter Barker, M.D., Associate Professor of Surgery, University of Illinois, College of Medicine  
MODERATOR: Jack Cooley, M.D., Assistant Professor of Surgery, University of Illinois College of Medicine and Chief Surgeon, Carle Clinic, and Hospital, Urbana

### Vascular Surgery

SURGEON: John Bergan, M.D., Associate Professor of Surgery Northwestern University; Attending Surgeon, Cook County Hospital  
MODERATOR: Gerald Moss, M.D., Associate Professor, University of Illinois, College of Medicine, Attending Surgeon, Cook County Hospital

### Biliary Surgery

SURGEON: Robert J. Freeark, M.D., Professor and Chairman, Department of Surgery and Chief of Surgery, Stritch School of Medicine, Loyola University  
MODERATOR: George Block, M.D., Professor of Surgery, Pritzker School of Medicine, University of Chicago

### Hand Surgery

SURGEON: John A. Boswick, Jr., M.D., Chairman, Department of Hand Surgery, Cook County Hospital;

Professor of Surgery, University of Illinois, College of Medicine

MODERATOR: William Requarth, M.D., Clinical Professor of Surgery, Abraham Lincoln School of Medicine, University of Illinois

11:00 a.m. Grand Rounds Hektoen Institute  
Auditorium

Frank C. Spencer, M.D., Professor and Chairman, Department of Surgery, New York University Medical School and Chief of Surgery, Bellevue Hospital, New York

Afternoon Session Arlington Park Towers Hotel  
Swaps Room

Charles B. Puëstow, M.D., Chairman

1:30 p.m. Hypercalcemia and the Surgeon

MODERATOR: Edward Paloyan, M.D., Professor of Surgery, Pritzker School of Medicine, University of Chicago

PANEL: Anne M. Lawrence, M.D., Associate Professor of Medicine, University of Chicago Medical School, and Eric Reiss, M.D., Chief of Medicine, Michael Reese Hospital, Professor of Medicine, University of Chicago Medical School

2:30 p.m. Coronary Revascularization

Frank C. Spencer, M.D.

3:30 p.m. Multiple Trauma

Robert Baker, M.D., Professor of Surgery, Abraham Lincoln School of Medicine, University of Illinois, Attending Surgeon, Cook County Hospital

PANEL: Jack C. Cooley, M.D., Chief of Surgery, Carle Clinic, Champaign-Urbana; Saul Levitsky, M.D., Associate Professor of Surgery, Abraham Lincoln School of Medicine, University of Illinois, and Glenn Dobben, M.D., Associate Professor of Radiology University of Illinois, Director of Radiology, Cook County Hospital

## ILLINOIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Monday, May 17 Discovery Room

10:00 a.m. Business Meeting

10:30 a.m. "Practical Diagnosis"

Jack Maidman, M.D., Department of Ob-Gyn, College of Medicine, University of Illinois

11 a.m. "The Use of the Computer in Obstetrics"

Michael McKeown, M.D., Department of Ob-Gyn, Pritzker School of Medicine, University of Chicago

11:30 a.m. "Concepts in Modern Obstetrical Anesthesia"

William Gottschalk, M.D., Director, Department of Obstetrical Anesthesia, Assistant Professor, OB-Gyn, and Assistant Professor, Anesthesiology, Northwestern University Medical School

1 p.m. "Delayed Ovulation"

Leslie Iffy, M.D., Associate Professor of Ob-Gyn, University of Illinois, College of Medicine

**1:30 p.m. "Prostaglandins—New Therapeutic Agents in OB-GYN"**

Kamran Moghissi, M.D., Professor of Ob-Gyn School of Medicine, Wayne State University, Detroit, Michigan

**2 p.m. "Chemotherapy in the Treatment of Gynecologic Malignancy"**

Edward Savage, M.D., Assistant Professor, Ob-Gyn, College of Medicine, University of Illinois

**2:30 p.m. Exhibit Break**

**2:45 p.m. Panel Discussion: "Should the Current Abortion Laws in Illinois Be Liberalized?"**

PRO: John S. Long, M.D., Presbyterian-St. Luke's Hospital, Chicago

John Holden, Th.D., Director, Westminster House, Chicago Medical Center, Chicago

ANTI: Eugene F. Diamond, M.D., Stritch School of Medicine, Loyola University, Chicago

Hanna Klaus, M.D., Assistant Professor, Ob-Gyn, Medical School, St. Louis University

**MEDICAL MALPRACTICE  
ETIOLOGY, THERAPY &  
PROPHYLAXIS**

Monday, May 17 10:30 a.m. Swaps Room

MODERATOR: Herman Wing, M.D., LLB.

**Anatomy of a Malpractice Claim**

Lawyer Leonard C. Arnold, M.D., Juris Doctor, Fellow of Legal Medicine

**Summary and Perspectives**

Clinton Compere, M.D., Chairman, ISMS Legal Council

**Questions and Answers**

**MEDICINE AND RELIGION**

Monday, May 17 Equipoise-Whirlaway

Presentation of 1971 Medicine & Religion Awards

**10:30 a.m. "Faith and Reason in Healing"**

William B. Walsh, M.D., Founder and President of Project HOPE

**1:00 p.m. "Medicine and Religion Workshop"**

Arne E. Larson, Director, Department of Medicine and Religion, American Medical Association

**DIABETES PROJECT**

Monday, Tuesday, Wednesday, May 17, 18, 19

10:30 a.m. Nashua Room

A three part project in continuing education presented by USV Pharmaceutical Corporation

1. A new documentary film
2. A comprehensive monograph
3. A physician self-evaluation section

**TODAY'S YOUTH**

Monday, May 17

1:30 p.m. Citation Room

MODERATOR: Leona B. Yeager, M.D., Director, Student Health Service, Northwestern University

**"Youth Alienation and the Drug Scene"**

David E. Smith, M.D., Founder and Director of Haight-Ashbury Medical Clinic; Consultant on Drug Abuse, Department of Psychiatry, San Francisco General Hospital; Assistant Clinical Professor of Pharma-

cology, Medical Center, University of California; Member, U.S. Office of Education's Drug Education National Action Committee, and Editor, *Journal of Psychedelic Drugs*

**"Sex Counseling in a University Setting"**

Philip Sarrel, M.D., Assistant Professor of Ob-Gyn, School of Medicine, Yale University, and Lorna Sarrel, M.S.W., Consultant in Sex Problems, School of Medicine, Yale University, New Haven, Conn.

**IMPAC ANNUAL MEETING**

Monday, May 17

Sea Biscuit

4:15 p.m.

**PUBLIC AFFAIRS DINNER**

Monday, May 17

Parlors 4 & 5

6:00 p.m. Reception

7:00 p.m. Dinner

8:00 p.m. Program,

Featuring Mark Russell, political satirist and Lt. Gov. Paul Simon

**ALLERGY**

Tuesday, May 17

Discovery Room

**9:00 a.m. "Aspergilosis in a Family"**

Vichare Vithayasai, M.D., Resident, Pediatric Allergy Presbyterian-St. Luke's Hospital, Chicago

**9:15 a.m. "Cardiac Allergy"**

Robert Boxer, M.D., Consultant in Allergy, Lutheran General and Skokie Valley Hospitals.

**9:30 a.m. "Parotid Gland Allergy"**

Joseph Interlandi, M.D., Consulting Physician, Westlake Community Hospital, Chicago, and Clinical Assistant Professor, Loyola Dental School

**9:45 a.m. "Perforated Nasal Septum Due to Nasal Sprays"**

Martin Kaplan, M.D., Associate in Pediatrics, Medical School, Northwestern University, and Chairman, Pediatrics, Highland Park Hospital.

**10:00 a.m. "Paradoxical Effects of Isuprel Aerosol Therapy in Status Asthmaticus"**

Herman Schemberg, M.D., Associate Attending Physician, Michael Reese Hospital, Chicago

**10:15 a.m. "Ophthalmic Allergy Due to Hormodendrum"**

Lawrence Elegant, M.D., Assistant Clinical Professor of Pediatrics, Chicago Medical School, and Co-Director, Pediatric Allergy Clinic, Michael Reese Hospital, Chicago

**11:00 a.m. "Rehabilitation of the Asthmatic Child"**

Merle Scherr, M.D., Medical Director (Medical Director, Allergy Rehabilitation Foundation, Inc. Camp for Asthmatic Children) Charleston, West Va.

**TREATMENT CONSIDERATIONS IN  
ANXIETY AND TENSION  
DEPRESSION AND SUICIDE,  
EMOTIONAL PROBLEMS OF THE AGED**

Presented by Sandoz Pharmaceuticals, Hanover, N.J.

MODERATOR: Jackson Smith, M.D.

**"Anxiety and Tension"**

Jackson Smith, M.D., Professor and Chairman, Department of Psychiatry, Stritch School of Medicine, Loyola University



### **"Depression and Suicide"**

Gerald Klerman, M.D., Professor of Psychiatry, School of Medicine, Harvard University

### **"Emotional Problems of the Aged"**

Jack Weinberg, M.D., Clinical Director, Illinois State Psychiatric Institute, and Professor of Psychiatry, College of Medicine, University of Illinois

## **ACADEMY OF PREVENTIVE MEDICINE**

Tuesday, May 18 Luncheon Discovery Room  
12 noon "Legal and Other Aspects of Abortion on Demand"

Victor Rosenbloom, Professor of Law, Northwestern University

## **FIFTY YEAR CLUB LUNCHEON**

Tuesday, May 18 Equipoise-Whirlaway  
12 noon "The Changing Practice of Medicine"  
T. R. Van Dellen, M.D., Editor, *IMJ*, and author of the syndicated column, "How to Keep Well"

## **RADIOLOGY**

Presented by the Illinois Chapter,  
American College of Radiology

Tuesday, May 18 War Admiral Room  
1:30 p.m. "Inferior Vena-Cavography"  
Dr. Ernest Ferris, Professor of Radiology, Boston University, Boston, Massachusetts

2:15 p.m. Exhibit Break  
3:00 p.m. "Film Reading"  
Rogelio Moncada, M.D., Stritch School of Medicine, Loyola University, and Jerry Petasnik, M.D., Assistant Professor, Rush Medical School; Charles H. Williams, M.D., Radiologist, Springfield Memorial Hospital, and Michael Snyder, M.D., Radiologist, St. John's, Springfield

4:00 p.m. Business Meeting  
5:00 p.m. Cocktail Party

## **PHYSICIANS' ASSISTANTS**

Tuesday, May 18 Swaps Room  
1:30 p.m.  
MODERATOR: Lawrence L. Hirsch, M.D.

## **THIRD ANNUAL CANCER SYMPOSIUM**

Co-sponsored by the American Cancer Society,  
Chicago Unit, and the ISMS

2 p.m. Citation Room  
MODERATOR: Gerald O. McDonald, M.D., Professor of Surgery, Abraham Lincoln School of Medicine, University of Illinois, and President, American Cancer Society, Chicago Unit Chairman

### **Carcinoma of the Breast**

"Evaluation of Diagnostic Techniques-Mammography, Thermography, and Xeroradiology"

Franklin S. Alcorn, M.D., Attending Radiologist, Rush Presbyterian-St. Luke's Medical Center, and Associate Professor of Radiology, Rush Medical School

"Principles and Results of Surgical Treatment"

Donald J. Ferguson, M.D., Ph.D., Professor of Surgery, Pritzker School of Medicine, University of Chicago

## **Soft Tissue Tumors—Early Recognition and Principles of Treatment**

### **"Melanoma"**

Harry W. Southwick, M.D., Professor of Surgery, Rush Medical School

### **"Soft Tissue Sarcomas"**

Tapas Das Gupta, M.D., Ph.D., Professor of Surgery, Abraham Lincoln School of Medicine, University of Illinois.

## **PATHOLOGY**

Tuesday, May 18 Room 122  
6:00 p.m. Dinner  
Wednesday, May 19 Hektoen Institute  
1:30 p.m. Slide Seminar Cook County Hospital

## **ANNUAL ISMS PRESIDENT'S BANQUET AND UNIVERSITY OF ILLINOIS MEDICAL ASSOCIATION DINNER**

Tuesday, May 18 Parlors 4 & 5  
6:00 p.m. Cocktails  
7:00 p.m. Dinner  
Music ★ Dancing ★ Entertainment  
Featuring  
The Incomparable Hildegarde

## **UNIVERSITY OF ILLINOIS MEDICAL ALUMNI DAY**

Tuesday, May 18 Tour of University of Illinois  
10:30 a.m. to 2:15 p.m. Medical Center Campus  
Alumni and interested non-alumni welcome. Bus tour, box lunch and soft drinks, \$3.  
10:30 a.m. Bus leaves from front of Arlington Park Towers  
11:15 a.m. Tour of the medical center including TV studio, The Center for Educational Development and new buildings  
1:00 p.m. Pick up box lunch  
1:15 p.m. Bus leaves for Arlington Towers

## **SOCIAL RESPONSIBILITY AND THE MEDICAL COLLEGE**

2:30-3:30 p.m. Discovery Room  
"Meet the Deans"—Executive Dean William J. Grove will present a progress report on the evolving changes in the College of Medicine in which six component colleges will greatly increase the training of medical personnel. Deans of these schools will outline individual developments including plans for training in family practice.  
3:30-4:00 p.m. "Delivery of Health Care in the Inner City"

Edsel K. Hudson, Associate Professor of Medicine and also of Preventive Medicine and Community Health, will discuss problems and progress in the "Valley Outpost," the College of Medicine's venture in providing comprehensive health care to a nearby community

4:00-4:30 p.m. "State Wide Trauma Program"

David R. Boyd, Research Associate in Surgery, dramatizes the lifesaving benefits of an organized program which exploits the latest techniques of transportation and medical care of trauma patients.

6 p.m. Social Hour and Banquet Parlors 4 & 5  
Presentation of Alumnus of the Year Awards—election of officers and presentation of plaque to outgoing president; recognition of reunion classes.

## PEDIATRICS

**Wednesday, May 19** **War Admiral**  
Presented by the Illinois Chapter, American Academy of Pediatrics in conjunction with ISMS

**10:15 a.m. "Pediatric Renal Disease: New Solutions to Old Problems"**

Dr. Ronald Kallen, M.D., Assistant Professor of Pediatrics Pritzker School of Medicine, University of Chicago

**10:45 a.m. "Intestinal Obstruction in Infants"**

Dr. Hugh Firor, Associate Professor of Pediatric Surgery, Abraham Lincoln School of Medicine, University of Illinois, Assistant Director, Pediatric Surgery, Cook County Hospital

**11:45 a.m. "High Risk Concept in Pediatrics and the Study of Malformation Syndrome in Man"**

Dr. John Opitz, University of Wisconsin, Madison

**12:15 p.m. Luncheon** **Sea Biscuit**

## FAMILY PHYSICIANS' LUNCHEON

**Wednesday, May 19** **Discovery Room**  
Sponsored by the Illinois Academy of General Practice  
**12:00 noon**

## EMERGENCY ROOM PROBLEMS & PROCEDURES

Workshop for Physicians, Nurses and Technicians

**Wednesday, May 19** **Swaps Room**

**1:30 p.m.** Workshop Panelists:

George T. Anast, M.D., Chairman, Postgraduate Course for Emergency Room Department Nurses, Chicago Committee on Trauma, American College

of Surgeons, Senior Attending Orthopedic Surgeon, Ravenswood Hospital Medical Center, Attending Orthopedic Surgeon, Cook County Hospital  
David R. Boyd, M.D., Assistant Professor of Surgery, Abraham Lincoln School of Medicine, University of Illinois

Harold A. Paul, M.D., Associate Professor of Surgery, Rush Medical College  
John Schneewind, M.D.

## WHAT YOUR PATIENTS EXPECT YOU TO KNOW ABOUT HUMAN SEXUALITY

Presented by Lederle Laboratories, Pearl River, New York  
**Wednesday, May 19** **Citation Room**

**1:30 p.m. "What Doctors Are Asking About Sexuality"**

Gerlad Egelston, Lederle Laboratories, will discuss the most asked questions at 83 symposia on Clinical Aspects of Sexuality.

**"Sexual Pressures in Today's Society"**

Mary Calderone, M.D., M.P.H., Executive Director, Sex Information and Education Council of the United States, New York

**"Sex As Non-Willed Behavior"**

Joseph B. Trainer, M.D., Professor of Medicine, University of Oregon Medical School, Portland

**"How to Talk Sex & Keep Your Cool"**

Martin Goldberg, M.D., Bala Cynwyd, Pa.

**"Violent Sex, Destructive Deviate Behavior"**

Beverly T. Mead, M.D., Professor and Chairman, Department of Psychiatry, Creighton University School of Medicine, Omaha, Neb.

Rap Session based on written questions from the audience.

# Instructional Courses

The Committee on Scientific Assembly, by authority and with the encouragement of the Illinois State Medical Society Board of Trustees, is pleased to present a new feature at the 1971 ISMS annual meeting.

On the following pages are descriptions of 36 instructional courses to be presented from 8:30 to 10:00 a.m. each day of the convention. These classes will be limited in size so that there will be ample opportunity for discussion with the instructor.

Advance registration is required.

Robert T. Fox, M.D. *Chairman*

J. Robert Thompson, *Director of Exhibits*

Roger Hoekstra, M.D. Laurel E. Keith, M.D.

Elizabeth McGrew, M.D. Donald L. Unger, M.D.

Gerald V. Stanton, *SAMA Representative*

Mrs. Mitchell Spellberg, *Auxiliary Representative*

## Plan of Presentation

**Monday, May 17, 1971**

**8:30 - 10:00 a.m.**

101 Obstetrical Analgesia & Anesthesia

Ralph A. Reis, M.D.

102 Current Role of Pacemakers

Laurence H. Rubinstein, M.D.

Benjamin Kaplan, M.D.

103 Therapeutic Use of Blood Components

James B. Hartney

Kenneth Schneider, M.D.

Fedor Bachman, M.D.

J. M. Baron, M.D.

104 Multiphasic Lab. Screening

Coye C. Mason, M.D.

105 New Advances in Management of Parkinson's Disease

Louis D. Boshes, M.D.

106 The Role of Dialysis in Renal Problems

Bernard Adelson, M.D.



- 107 The Mechanics of an Anti-Smoking Clinic  
Chaplain Willis Graves  
David V. Lounsberry, M.D.
- 108 Making the Pap Smear Reliable  
Elizabeth McGrew, M.D.
- 109 What's New in Hepatitis  
Mitchell A. Spellberg, M.D.
- 110 Migraine & Other Headaches  
Joel Brumlik, M.D.
- 111 Use and Abuse of Antibiotics and Chemotherapeutic Remedies  
Martin H. Seifert, M.D.
- 112 Management of Indwelling Urethral Catheter  
John B. Nanninga, M.D.

## **Tuesday, May 17, 1971**

**8:30 - 10:00 a.m.**

- 201 Optimal & Minimal Requirements for an Emergency Room  
Robert J. Freeark, M.D.
- 202 Drug Reactions  
Arthur H. Rosenblum, M.D.
- 203 Asthma  
Donald L. Unger, M.D.
- 204 Hemoptysis—Diagnostic Methods  
Thomas Shields, M.D.
- 205 Place of Exercise & Diet in Cardiac Patients  
Jeremiah Stamler, M.D.
- 206 The Depressed Patient  
John Cowen, M.D.  
H. H. Garner, M.D.  
James W. Crawford, M.D.
- 207 Control of Conception  
John Isaacs, M.D.
- 208 Current Therapy of Burns  
John A. Boswick, M.D.  
George E. Collentine, M.D.
- 209 Epigastric Distress  
George Block, M.D.
- 210 Hematuria  
J. Kenneth Sokol, M.D.
- 211 New Approaches in Rehabilitation of the Arthritic  
John J. Nicholas, M.D.
- 212 Management of the Inebriate  
David J. Stinson, M.D.

## **Wednesday, May 19, 1971**

**8:30 - 10:00 a.m.**

- 301 Current Therapy of Hypertension  
Peter J. Talso, M.D.
- 302 Late Onset Diabetes  
Sheldon Berger, M.D.
- 303 Anticoagulant Therapy  
Raymond A. Dieter, M.D.  
Irving A. Friedman, M.D.  
Patrick Scanlon, M.D.
- 304 Pediatric Rehabilitation  
Jane Borges, M.D.
- 305 Adenotonsillectomy and Myringotomy Indication in 1971  
Burton J. Soboroff, M.D.
- 306 Team Approach to NP Problems  
John W. Lauer, M.D.
- 307 Current Management of V.D.  
Louise E. Tavs, M.D.

- 308 Recognition & Management of the Drug Victim  
Joseph H. Skom, M.D.
- 309 Current Immunization Practices  
Charles Kallick, M.D.
- 310 Athletic Injuries of the Knee  
Theodore A. Fox, M.D.
- 311 Role of Inhalation Therapy & Pulmonary Function Studies in Community Hospitals  
Albert A. Andrews, M.D.  
Richard Tomasson, M.D.  
Kenrad E. Nelson, M.D.
- 312 Medical Aspects of Pollution & the Physician's Role in Diagnosis, Treatment, & Prevention  
Bertram W. Carnow, M.D.

## **Instructional Courses**

Course 101: Monday, 8:30-10:00 a.m.

### **OBSTETRICAL ANALGESIA & ANESTHESIA**

Ralph A. Reis, M.D., Professor Emeritus Obstetrics & Gynecology, Northwestern University School of Medicine.

Discussion of pain reflected during labor; analgesia and anesthesia for delivery.

Course 102: Monday, 8:30-10:00 a.m.

### **CURRENT ROLE OF PACEMAKERS**

Lawrence Rubinstein, M.D.

Attending Thoracic Surgeon, Michael Reese Hospital, Associate Professor Surgery, Chicago Medical School.

Dr. Benjamin Kaplan, Attending Cardiologist, Michael Reese Hospital, Clinical Assistant Professor, University of Illinois, Abraham Lincoln School of Medicine. Medical and surgical experience over past 10 years with pacemakers.

Course 103: Monday, 8:30-10:00 a.m.

### **THERAPEUTIC USE OF BLOOD COMPONENTS**

James B. Hartney, M.D., Associate Clinical Professor, Pathology, Stritch School of Medicine, Loyola University, Moderator

Panel Discussion: Dr. Kenneth Schneider, Pathologist, Wesley Memorial Hospital, discussing uses of anti-hemophilic factors; Dr. J. M. Baron, Assistant Professor, Department of Medicine, Section of Hematology, University of Chicago, Pritzker School of Medicine, will be concerned with uses of red blood cell concentrates, and Dr. Fedor Bachmann, Chief of Calibrating Laboratory, Pres. St. Lukes will discuss the use of platelet concentrates.

Course 104: Monday, 8:30-10:00 a.m.

### **MULTIPHASIC LAB. SCREENING**

Coye C. Mason, M.D., Director, Mason Barron Pathology Laboratories, SC

The use of automated laboratory instrumentation makes it possible to accumulate important data in hematology and biochemistry which depicts important patterns of disease. A few minutes, in a very informal way, will be used to show what is available to the practicing physician. Many examples of "Patterns of Disease," will be shown. The participants will be urged to engage in the discussion with questions and answers.

Course 105: Monday, 8:30-10:00 a.m.

### **NEW ADVANCES IN MANAGEMENT OF**

#### **PARKINSON'S DISEASE**

Louis D. Boshes, M.D., Clinical Professor of Neurology, University of Illinois, College of Medicine. Senior Attending Neurologist, Michael Reese Hospital & Medical Center.

Medical treatment of parkinsonism's syndrome will be re-

viewed with particular reference to the mechanism of action, of conventional antiparkinson drugs; Amantadine (Symmetrel) and finally L-DOPA. The role of surgery will be explored. The current pathophysiology of parkinsonism will be discussed.

Course 106: Monday, 8:30-10:00 a.m.

#### THE ROLE OF DIALYSIS IN RENAL PROBLEMS

Bernard Adelson, M.D., Assistant Professor of Medicine, Northwestern University Medical School, Attending Physician and Director of Nephrology and Artificial Kidney Unit, Evanston Hospital.

Dialysis in the majority of patients with kidney disease and evaluation of the role of dialysis in the treatment of the following given problems: acute uremia; chronic unemia; and acute drug intoxication.

Course 107: Monday, 8:30-10:00 a.m.

#### THE MECHANICS OF AN ANTI-SMOKING CLINIC

Champlain Willis C. Graves, Hinsdale Sanitarium and Hospital; David Lounsberry, M.D.

A resume of the "5 Day Plan" to stop smoking will be presented. The purpose of this program is to educate the public of the health hazards related to smoking, the psychological aspects, as well as providing group therapy is the "Kick the Habit."

Course 108: Monday, 8:30-10:00 a.m.

#### MAKING THE PAP SMEAR RELIABLE

Elizabeth McGrew, M.D., Professor of Pathology, University of Illinois, Abraham Lincoln College of Medicine.

Discussion of critical points in the collection and handling of cellular specimens and selection of the proper laboratory to obtain greatest usefulness of cellular studies.

Course 109: Monday, 8:30-10:00 a.m.

#### WHAT'S NEW IN HEPATITIS

Mitchell A. Spellberg, M.D., Clinical Professor of Medicine, University of Illinois, Abraham Lincoln School of Medicine, Acting Chairman, Division of Gastro-enterology, Michael Reese Hospital, Chicago.

Discussion will revolve around various etiologic factors producing hepatitis, but with specific emphasis of the viral type of hepatitis, both the infection and post-transfusion type. The Current concept epidemiology of these two types of hepatitis will be discussed and emphasis on prevention and treatment. The change in the clinical course of viral hepatitis has been noted by us and this includes patients who have been exposed to drugs as well as non-drug users.

The relationship of the Australian Augenitgen or hepatitis associated augenitgen to various types of hepatitis will be touched upon. The histology both by light microscopy and electron microscopy will be illustrated with slides.

Course 110: Monday, 8:30-10:00 a.m.

#### MIGRAINE & OTHER HEADACHES

Joel Brumlik, M.D., Professor & Chairman, Dept. of Neurology, Loyola University, Stritch School of Medicine.

Clinical picture and pathophysiology of the vascular headaches (migraine and its variants), muscle contraction headache and others. The evaluation of the headache patient and management of the problem will be discussed.

Course 111: Monday, 8:30-10:00 a.m.

#### USE AND ABUSE OF ANTIBIOTICS

##### & CHEMOTHERAPEUTIC REMEDIES

Martin H. Seifert, M.D., Associate Professor of Medicine, Northwestern University, Medical School.

An attempt to relationalize the use of these remedies and prevent their over-use, producing a sensitivity and complications in patients, and resistance in micro-organisms.

Course 112: Monday, 8:30-10:00 a.m.

#### MANAGEMENT OF INDWELLING URETHRAL CATHETER

John B. Nanninga, M.D., Instructor of Urology, Northwestern University, School of Medicine.

Course will include (1) indications for the catheter; (2) insertion techniques; (3) care of the catheter; and (4) types of catheters.

Course 201: Tuesday, 8:30-10:00 a.m.

#### OPTIMAL & MINIMAL REQUIREMENTS FOR AN EMERGENCY ROOM

Robert Freeark, M.D., Professor & Chairman, Department of Surgery and Chief of Surgery, Loyola University Stritch School of Medicine.

Review of current and proposed standards for various types of hospital emergency departments.

Course 202: Tuesday, 8:30-10:00 a.m.

#### DRUG REACTIONS

Arthur H. Rosenblum, M.D., senior attending, Department of Allergy & Pediatrics, Michael Reese Hospital & Medical Center.

A presentation of drug allergy, including allergy to Penicillin, ACTH, and vaccines. A discussion of toxic reaction to various drugs, including Ilosone, Methyseril, Sulfa drugs and others. After a former presentation, informal discussion will follow.

Course 204: Tuesday, 8:30-10:00 a.m.

#### ASTHMA

Donald L. Unger, M.D., Associate Professor, Stritch School of Medicine, Loyola University; Chief, Allergy Clinic at Stritch.

Relationship of Asthma to other allergic diseases; Diagnosis and differential diagnosis of asthma; the allergic triad (asthma, nasal polyps and aspirin sensitivity); causes of death in asthma; management of asthma and status asthmaticus; rehavilitation of asthmatic children.

Course 204: Tuesday, 8:30-10:00 a.m.

#### HEMOPTYSIS-DIAGNOSTIC METHODS

Thomas Shields, M.D., Professor of Surgery, Northwestern University Medical School.

Appropriate methods of investigation for the determination of the source of hemoptysis will be considered in both the patients with normal chest roentgenogram, and those with abnormal roentgenographic findings. The various diagnostic procedures utilized and the indication for their use will be outlined.

Course 205: Tuesday, 8:30-10:00 a.m.

#### PLACE OF EXERCISE & DIET IN CORONARY PATIENTS

Jeremiah Stamler, M.D., Associate Professor, Department of Medicine, Northwestern University School of Medicine; Professional erturer, Department of Medicine, University of Chicago Pritzker School of Medicine.

The presentation will review the possible role and methodology of diet therapy for the control of obesity, hyperlipidemia, hypertension and diabetes. It will also review the problems inherent in exercise prescription for the coronary patient, indicating the evidence for and against the view that this may be efficacious in prolonging life. It will present detailed information concerning the methodology of writing a precise prescription for exercise for the coronary patient, together with precautions to minimize risk of complications, both cardiovascular and musculoskeletal.

Course 206: Tuesday, 8:30-10:00 a.m.

#### THE DEPRESSED PATIENT

John Cowen, M.D., Clinical Professor of Psychiatry, University of Health Sciences, The Chicago Medical



School; James W. Crawford, M.D., Clinical Associate Professor of Psychiatry & Behavioral Sciences, Associate Director, Undergraduate Education, The Chicago Medical School, and H. H. Garner, M.D., Professor & Chairman, University Health Sciences, The Chicago Medical School.

A panel discussion on separate aspects, e.g., the clinical features, and suicidal possibilities and the differential diagnosis and treatment.

Course 207: Tuesday, 8:30-10:00 a.m.

#### CONTROL OF CONCEPTION

John Isaacs, M.D., Clinical Professor of Obstetrics & Gynecology, Loyola University Stritch School of Medicine.

Indications and contraindications for various types of contraceptives. Discussion of clinical side effects and their management.

Course 208: Tuesday, 8:30-10:00 a.m.

#### CURRENT THERAPY OF BURNS

John A. Boswick, M.D., Chairman, Dept. of Hand & Burn Surgery, Cook County Hospital, Professor of Surgery, U. of Ill., and George Collentine, Jr., M.D., Assistant Professor of Surgery, Marquette School of Medicine, Milwaukee, Wis.

Management of the initial phase of burn patient care.

Course 209: Tuesday, 8:30-10:00 a.m.

#### EPIGASTRIC DISTRESS

George Block, M.D., Professor of Surgery, University of Chicago, Pritzker School of Medicine.

Discussion with gastroenterologist as to various disease entities that can present as epigastric distress; their diagnosis and treatment.

Course 210: Tuesday, 8:30-10:00 a.m.

#### HEMATURIA

J. Kenneth Sokol, M.D., Associate Professor of Urology, Northwestern University Medical School

The etiology, history, physical examination, laboratory studies and other diagnostic studies used to reach the diagnosis of the cause of hematuria will be discussed.

Course 211: Tuesday 8:30-10:00 a.m.

#### NEW APPROACHES TO REHABILITATION OF THE ARTHRITIC

John J. Nicholas, M.D.

Course 212: Tuesday, 8:30-10:00 a.m.

#### MANAGEMENT OF THE INEBRIATE

David J. Stinson, M.D.

Course 301: Wednesday, 8:30-10:00 a.m.

#### CURRENT THERAPY OF HYPERTENSION

Peter J. Talso, M.D., Medical Director, Little Company of Mary Hospital.

Discussion of etiology and epidemiology of hypertension. Correctable hypertension and medical management of hypertension.

Course 302: Wednesday, 8:30-10:00 a.m.

#### LATE ONSET DIABETES

Sheldon Berger, M.D., Associate Professor of Medicine, Northwestern University Medical School.

A current view of the pathogenesis of this condition. An approach to its management.

Course 303: Wednesday, 8:30-10:00 a.m.

#### ANTICOAGULANT THERAPY

Irving Friedman, M.D., Clinical Professor of Medicine, Loyola University, Stritch School of Medicine; Raymond A. Dieter, Jr., M.D., Thoracic Surgeon, Loyola University, Stritch School of Medicine; and Patrick Scanlon, M.D.

Current concepts of the clotting mechanism; anticoagulant drugs; indications; and complications.

Course 304: Wednesday, 8:30-10:00 a.m.

#### PEDIATRIC REHABILITATION

Jane Borges, M.D., Associate in Rehabilitation, Northwestern University Medical School.

Total evaluation of the child in habilitation and rehabilitation. The important role of parent, school and community.

Course 305: Wednesday, 8:30-10:00 a.m.

#### ADENOTONSILLECTOMY & MYRINGOTOMY—INDICATIONS FOR 1971

Burton J. Soboroff, M.D., Professor of Otolaryngology, Abraham Lincoln School of Medicine, College of Medicine, University of Illinois.

An increasing incidence of serious otitis media and hearing loss in children makes review of the indications for T & A, myringotomy and the use of plastic tubes essential for all physicians who treat these patients.

Course 306: Wednesday, 8:30-10:00 a.m.

#### TEAM APPROACH TO NP PROBLEMS

John W. Lauer, M.D., Assistant Professor, Dept. of Psychiatry, Northwestern University Medical School; Senior attending psychiatrist, Chicago Wesley Memorial Hospital.

Seminar style program designed for a small group. Additional participants in the course will be Miss Karla Klein, M.A., Psychologist and Mr. Morton E. Levin, ACSW, a social worker.

Course 307: Wednesday, 8:30-10:00 a.m.

#### CURRENT MANAGEMENT OF V.D.

Louise E. Tavs, M.D., Associate Professor of Clinical Dermatology U. of Illinois, College of Medicine, and Assistant Director, of V.D. Clinic of Chicago Health Department.

Modern concepts of the clinical and laboratory diagnosis of acquired and congenital syphilis; current indications for doing a spinal tap; treatment of syphilis with penicillin and schedules of treatment for penicillin-sensitive patients; typical problem cases for discussion. New, helpful laboratory procedures in the diagnosis and post-treatment management of gonorrhea in the male and female; discussion of treatment. A new and easy laboratory procedure in the diagnosis of chancroid, which is showing a sharp incidence rise at present; treatment of chancroid.

Course 308: Wednesday, 8:30-10:00 a.m.

#### RECOGNITION & MANAGEMENT OF THE DRUG VICTIM

Joseph H. Skom, M.D., Assistant Professor of Medicine, Northwestern University Medical School, Chairman, ISMS Committee on Narcotics

Diagnosis and treatment of acute and chronic drug responses.

Course 309: Wednesday, 8:30-10:00 a.m.

#### CURRENT IMMUNIZATION PRACTICES

Charles Kallick, M.D., Director of Ambulatory Pediatrics, Rush-Presbyterian Medical Center, and Assistant Professor of Pediatrics, Rush Medical College.

Current schedules for immunizations; hazards and complications of immunizations.

Course 310: Wednesday, 8:30-10:00 a.m.

#### ATHLETIC INJURIES TO THE KNEE

Theodore A. Fox, M.D., Associate Professor of Orthopaedic Surgery, University of Illinois, College of Medicine.

Will discuss functional anatomy and mechanisms of internal derangement of the knee joint as well as ligamentous injuries; the diagnosis and differential diagnosis.

Course 311: Wednesday, 8:30-10:00 a.m.

#### **ROLE OF INHALATION THERAPY & PULMONARY FUNCTION**

Albert A. Andrews, M.D., Professor Bronchoesophagology & Head Department, Otolaryngology, Abraham Lincoln School of Medicine College of Medicine, University of Illinois, Richard Tomasson, M.D., Associate Professor of Anesthesiology, Abraham Lincoln School of Medicine, College of Medicine, University of Illinois, and Kenrad E. Nelson, M.D., Assistant Professor, Preventive Medicine & Community Health, Abraham Lincoln School of Medicine, College of Medicine, University of Illinois.

Pulmonary function studies are presented as a basis for physiologically directed inhalation therapy. Modalities of therapy appropriate for community hospital will be discussed with special emphasis on evaluation of response and prevention of infections.

Course 312: Wednesday, 8:30-10:00 a.m.

#### **MEDICAL ASPECTS OF POLLUTION AND THE PHYSICIAN'S ROLE IN DIAGNOSIS, TREATMENT & PREVENTION**

Bertram W. Carnow, M.D., Chief, Section on Environmental Health and Associate Professor, Department of Preventive Medicine and Community Health, University of Illinois, College of Medicine, Abraham Lincoln School of Medicine.

The course will deal with all aspects of environmental pollution and disease including description of etiologic agents, diagnosis of environmental diseases, diagnosis and treatment of environmental hyperreactors, pathophysiology and prevention. Findings for five studies on morbidity and mortality in relation to air pollutants will be briefly discussed.

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## **Scientific Exhibits - 1971**

### **"What the Physician Can Do About Cancer"**

American Cancer Society, Illinois Division, Inc.  
Chicago, Illinois 60603

### **"Pacemakers in Heart Disease"**

A. H. Khazei, M.D., I. Sejdinaj, M.D., R. Powers, M.D.  
Sherman Hospital, St. Joseph Hospital, St. Alexius Hospital  
Elgin, Illinois 60120

### **"Medical Aspects of Sports"**

American College of Sports Medicine  
Madison, Wisconsin 53706

### **"Unusual Problems of Hair Transplantation"**

D. B. Stough, III, M.D.  
Hot Springs, Arkansas 71901

### **"Results of a Computerized Study of Cyclic Hormonal Treatment"**

F. P. Rhoades, M.D.  
Detroit, Mich. 48226

### **"The Crucial Role of the Emergency Room in Management of Shock"**

William F. Mitty, Jr., M.D.  
St. Vincents Hospital, Dept. of Surgery  
New York, N.Y. 10011

### **"Chemosurgery for Recurrent and Invasive Cancer of the Skin"**

Barry A. Goldsmith, M.D.  
Univ. of Illinois  
Chicago, Ill.

### **"Pharmacologic Properties and Clinical Effects of Estrogen in the Human"**

Herbert S. Kupperman, M.D., Ph.D.  
New York, N.Y. 10016

### **"Pedicle Flaps in Reconstructive Surgery"**

M. Eugene Tardy, Jr., M.D., L. T. Tenta, M.D. and  
N. J. Pastorek, M.D.  
Univ. of Ill.  
Chicago, Ill. 60612



# Technical Exhibits

**Booth T-1**  
**HOMEMAKERS & NURSING**  
**SERVICES, INC.**  
**Chicago, Ill.**

**Booth T-2**  
**COCA-COLA**  
**U.S.A.**

Stop by our booth for a free Coke or Fresca. Coca-Cola . . . It's the real thing! And sugar-free Fresca . . . only two calories per 8 ounce serving.

**Booth T-3**  
**RICHARDS MANUFACTURING**  
**COMPANY**  
**Des Plaines, Ill.**

Richards Manufacturing Company will display a complete line of operating room instruments and implants and emergency room, cast room, and central supply items. Of special interest will be pre-padded splints, rib belts, binders, arm slings, etc. most used in the doctor's office. The Miles Vena Cava Clip will be shown also.

**Booth T-4**  
**INDECON, INC.**  
**Chicago, Ill.**

Indecon, Inc., Health Services Division, Chicago (branch offices in San Francisco and Indianapolis) is demonstrating their Computerized Patient Billing System, approved by ISMS. In addition to automated billing and preparation of major carrier insurance forms, the System generates all necessary receivables reports and practice management records.

**Booth T-5**  
**LAKE SIDE LABORATORIES, INC.**  
**Milwaukee, Wisc.**

Lakeside Laboratories, Inc., exhibit will feature Cantils, Imferon, Mercuhydrin, Metahydrin, Norpramin and the MedCom Learning System on Depression.

**Booth T-6**  
**CAPITAL RESOURCES CORP.**  
**Chicago, Ill.**

**Booth T-7**  
**BIO-MED LABORATORIES, INC.**  
**Milwaukee, Wisc.**

Bio-Med Laboratories, Inc. is a medically directed clinical laboratory service strategically located in the upper Midwest, thus providing a rapid, reliable service to physicians of this area. The service covers a wide range of procedures and a very carefully selected group called "Select-A-Panel". This grouping provides the physician

with an opportunity at a reasonable cost to construct a test panel offering the most efficient and comprehensive evaluation of his patient.

**Booth T-8**  
**ENCYCLOPAEDIA BRITANNICA, INC.**  
**Chicago, Ill.**

Encyclopaedia Britannica welcomes delegates to the Illinois State Medical Society Convention. As part of our exhibit we will have on display the great new edition of Britannica, Great Books of the Western World, the Britannica Junior and other related materials. Stop and inspect these products in Booth 8. They are available to the delegates at our convention offer.

**Booth T-9**  
**MERCK, SHARP & DOHME**  
**Division of Merck & Co., Inc.**  
**West Point, Pa.**

The Merck, Sharp & Dohme exhibit features subjects of scientific interest. Technically trained personnel are present to discuss the scope and variety of these services.

**Booth T-10-12**  
**DANIELS SURGICAL &**  
**MEDICAL SUPPLIES, INC.**  
**Chicago, Ill.**

DANIELS—with Mid-America's Ultra Modern Facilities to serve your Modern Professional Needs will again feature the newest in "top brand" equipment and supplies.

NEW—EXCLUSIVE LOW COST LEASE PLAN. SEE OUR COMPLETE EXAMINATION ROOM WITH EQUIPMENT & INSTRUMENTS FOR ONLY \$35.00 PER MO.

**Booth T-13**  
**APACHE CORPORATION**  
**Minneapolis, Minn.**

Apache Oil Programs, Inc. offers petroleum exploration investment programs for individuals and corporations. These programs are organized and professionally managed by Apache Corporation, an NYSE listed firm. They are accorded the tax incentive benefits of oil and gas exploration, and are suitable only for investors with substantial recurring taxable income.

**Booth T-14**  
**PARKE, DAVIS & COMPANY**  
**Detroit, Michigan**

Our representatives will be pleased to discuss selected pharmaceutical products at the Parke-Davis booth.

**Booth T-15**  
**WILLIAM H. RORER, INC.**  
**Ft. Washington, Pa.**

William H. Rorer, Inc. takes pride in exhibiting its fine

pharmaceutical products at this convention. Our representatives will gladly discuss Maalox, Camalox, Ascriptin, Quaalude and our other products with you.

**Booth T-16-17**  
**ILLINOIS BLUE CROSS-**  
**BLUE SHIELD PLAN**  
**Chicago, Ill.**

You are cordially invited to visit the Exhibit Booth of the Illinois Blue Cross-Blue Shield Plans. Our Professional Relations representatives will be happy to answer your questions about Blue Shield and Medicare, or to discuss the latest developments in health care protection. Helpful informative literature is on hand for you.

**Booth T-18**  
**HOECHST PHARMACEUTICAL**  
**COMPANY**  
**Somerville, New Jersey**

The representatives at Booth No. 18 will be happy to discuss Hoechst products with particular application to the physician's individual practice. Featured is Lasix® (furosemide), Surfak, Doxidan, Festal and Festalan.

**Booth T-19**  
**EQUITIES INTERNATIONAL, LTD.**  
**Chicago, Ill.**

Equities International, Ltd. is a financial planning and management firm mainly dealing with Practice Administration, Personal Budgeting, Estate Planning, Tax Sheltered Investment Programs, and Professional Corporation. We invite you to stop by our booth for a free, refreshing glass of orange juice and additional information.

**Booth T-20**  
**CONTOUR CHAIRS COMPANY**  
**Chicago, Ill.**

The Genuine Contour Chair in its home decor division is exhibited to acquaint Doctors with the many benefits to be derived from Complete Head-to-Foot Support and Body-Weight Distribution giving Rest and Relaxation from Sitting. By the producers of Blood-Bank, Dental, Podiatry, and Multiphasic Screening Chairs.

**Booth T-21**  
**GEOTEK RESOURCES FUND, INC.**  
**San Francisco, Cal.**

GeoTek Resources Fund, Inc. sells limited partnerships in oil development programs. It allows a tax shelter of approximately 70-95% of the total investment per program.

**Booth T-26**  
**CHICAGO TITLE AND TRUST**  
**COMPANY**  
**Chicago, Ill.**

Trust and investment services for the individual practitioner and the professional corporation.

**Booth T-27**  
**SANDOZ PHARMACEUTICALS**  
**Hanover, N.J.**

Sandoz Pharmaceuticals invites you to visit our display at Booth No. 27, where our representatives will be happy to provide you with complete information on our new product, SERENTIL!

**Booth T-27**  
**THE UPJOHN COMPANY**  
**Kalamazoo, Mich.**

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. They are here to discuss products of Upjohn research designed to assist you in the practice of your profession. They welcome your inquiries and comments.

**Booth T-29**  
**DATA SERVICE AGENCY, INC.**  
**St. Louis, Mo.**

Data Service Agency, Inc. serves the medical profession exclusively throughout Illinois and Missouri. They offer the physician, clinic, dentist and pharmacy, a complete accounts receivable service, with built-in sound and proven office management principles.

**Booth T-36**  
**LOMA LINDA FOODS**  
**Riverside, Calif.**

Loma Linda Foods, one of America's oldest manufacturers of fiber-free soy milk, will explain why the product SOYALAC is unusual in that it does not settle out, is milk-like in texture, and does not tend to raise infants' serum cholesterol. Samples of this flavorful, hypoallergenic milk will be served.

**Booth T-37**  
**PFIZER LABORATORIES**  
**New York, N.Y.**

You are cordially invited to visit the Pfizer Laboratories' exhibit. Our Professional Service Representatives in attendance will welcome your questions about our pharmaceutical products. You may be particularly interested in discussing Sinequan (Doxepin HCL) and Vibramycin (Doxycycline).

**Booth T-38**  
**CONTINENTAL BIO-CHEMICAL**  
**LABORATORY SERVICE, INC.**  
**Grand Rapids, Mich.**

CBC is a pathologist-directed laboratory dedicated to the highest standards of quality testing. This dedication extends to a pricing philosophy through automation and efficiency, that allows the prescribing of testing for many more patients at less cost than ordinarily possible.



**Booth T-39**  
**ASTRA PHARMACEUTICAL**  
**PRODUCTS INC.**  
**Worcester, Mass.**

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine) local and topical anesthetics, and the intravenous use of Xylocaine in the treatment of life-threatening cardiac arrhythmias will be available at the Astra booth.

**Booth T-40**  
**PAUL H. ROBINSON, JR., INC.**  
**Chicago, Ill.**

Booth No. 40 will be attended by Gary Kirke to explain to members the ISMS Retirement Programs. Also to service participants in both programs. Brochures will be displayed.

**Booth T-41**  
**MEDICAL PLASTICS**  
**LABORATORY, INC.**  
**Gateville, Tex.**

MEDICAL PLASTICS LABORATORY is the only company in the world today that molds skeletal reproductions from the actual bone, insuring the faithful duplication of each bone.

Through continuing research, the scientists and technicians of MP have been able to produce models with the color, texture, weight and X-ray opacity of actual bone, making them almost indistinguishable from real bone.

Doctors use them extensively to save time in complicated explanations of treatment and therapy, freeing them to see more patients, and aiding in the patients' understanding of problems involved.

**Booth T-42**  
**E. R. SQUIBB & SONS, INC.**  
**New York, N.Y.**

E. R. SQUIBB & SONS, Inc., are pleased to present a film review of 'up to date' and factual reports on current topics of medical interest and research. They include such topics as "Drug Abuse," "Aerospace Medicine," and "Heart Transplantation." This series of short films may be seen in our booth at anytime during the convention hours.

**Booth T-43**  
**THE DOYLE PHARMACEUTICAL**  
**COMPANY**  
**Minneapolis, Minn.**

*MERITENE*—Protein-vitamin-mineral supplement provides concentrated nutrition for patients having poor appetite or tolerance for ordinary foods.

*DIETENE*—For weight reduction. Provides optimum nutrition and maximum satiety without the use of drugs.

*CONTROLYTE*—A high-calorie, protein-free, low-electrolyte powder, served as a beverage or added to a variety

of foods to provide calorie fortification for the protein restricted diet.

*RESOURCE BAKING MIX*—Protein-free baking mix used for preparing bread and other baked foods.

**Booth T-44**  
**EXECUTIVE AUTO LEASING, INC.**  
**Lincolnwood, Ill.**

Executive Auto Leasing and its sister company Liberty Leasing are specialists in leases of autos and equipment to professional men. Executive Auto has 120 loaners and its own service department, and no piece of medical equipment is too large for Liberty. We give you ease of credit and maximum tax advantages.

**Booth T-46**  
**PM-ILLINOIS, INC.**  
**Bloomington, Illinois**

For almost 40 years the PM trademark has been the brand of distinction for the medical and dental professions, identifying the PM GROUP offices affiliated with Black & Skaggs Associates, Inc.

PM-ILLINOIS, INC., with offices in Bloomington, Chicago and Springfield, provides hundreds of Illinois physicians with professional management, personal and confidential business service.

Visit with the experienced PM executives. Their knowledge, wisdom and integrity are available to you.

**Booth T-47**  
**BRISTOL LABORATORIES**  
**Syracuse, N.Y.**

You are cordially invited to visit our exhibit reflecting Bristol's leadership and enduring commitment to the manufacturer of life-saving antibiotics.

For your consideration, the following Bristol antibiotics are featured: Polycillin® (ampicillin trihydrate), Kan-trex® (kanamycin sulfate) and Prostaphlin® (sodium oxacillin). Our representatives welcome the opportunity to answer your inquiries.

**Booth T-48**  
**NORTH AMERICAN PHARMACAL**  
**Dearborn, Mich.**

North American Pharmacal Company will welcome members of the medical profession at the company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. North American recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you, also available FREE CARICATURE DRAWINGS for physicians. We have a renowned artist, Mr. Chuck Kohl, at our booth to draw unique caricatures.

**Booth T-49**  
**MEAD JOHNSON LABORATORIES**  
**Evansville, Ind.**

'The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information.

To make your visit productive, specially trained representatives will be on duty to tell you about Vasodilan, Oracon 28, and Enfamil.

**Booths T-50-51**  
**ILLINOIS BELL TELEPHONE**  
**COMPANY**  
**Chicago, Ill.**

The Illinois Bell exhibits display telephone equipment that is available to the handicapped afflicted with hearing, motion or vision problems. Equipment is mounted with explanatory copy and includes special headsets, electronic larynx, headset amplifier, special call announcers, speaker-phone, school-to-home unit, braille and various other cards for card dialer and enlarged dial face. Brochures will be available at the exhibit for those interested in obtaining additional information.

**Booth T-52**  
**MEDFACT FILMS, MIDWEST, INC.**  
**Berwyn, Ill.**

Patient education is time consuming, monotonous, frustrating, repetitious, and difficult but IMPORTANT!!!

MEDFACT FILMS has the solution that is effective, practical, and economical with modern informative films in full color and sound in one easy loading cassette and automatic projector.

It's a matter of great time-saving to the doctor and a real medical-legal help as well.

Be sure to stop and review these films at Booth 52.

**Booth T-53**  
**ELI LILLY & CO.**  
**Indianapolis, Ind.**

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance will welcome your questions about our pharmaceutical products. You may be particularly interested in discussing our growing family of cephalosporins.

**Booth T-54**  
**USV PHARMACEUTICAL**  
**CORPORATION**  
**Tuckahoe, N.Y.**

USV invites you to stop at our exhibit to see how we're meeting the challenge of the 70s. We will feature: Arlidin—with a unique dual action

Cerespan—provides increase in blood flow

DBI-TD—a timed disintegration capsule that helps lower blood sugar.

And of course, Duo-CVP, Nitrospan, Bacid.

Our Professional Sales Representative will be able to give you full details.

**Booths T-55-56**  
**COMPUTA-LAB, INTERNATIONAL**  
**HEALTH SYSTEMS, INC.**  
**Des Plaines, Ill.**

Computa-Lab portable multiphasic health testing system.

**Booth T-57**  
**IMPERIAL FASHIONS**  
**Los Angeles, Calif.**

**Booth T-58**  
**ABBOTT LABORATORIES**  
**Chicago, Ill.**

You are cordially invited to visit the Abbott booth where Ogen® (piperazine estrone sulfate) in the new 21-Paks will be featured.

An interesting concept in the management of hypertension will also be available.

**Booth T-59**  
**W. B. SAUNDERS COMPANY—**  
**A DIVISION OF CBS, INC.**  
**Philadelphia, Pa.**

Saunders will have on display a complete line of their medical books, including many new titles and new editions published since last year's meeting—such as, Perloff: Congenital Heart Disease; Debre: Clinical Virology; DeLand and Wagner: Nuclear Medicine—Lung and Heart—Vol. II; Anson and McVay: Surgical Anatomy; Guyton: Medical Physiology; O'Donoghue: Injuries to Athletes; and many others.

**Booth T-60**  
**LEDERLE LABORATORIES**  
**Pearl River, N.Y.**

Lederle welcomes members and guests of the Illinois State Medical Society to visit Booth No. 60 where qualified representatives are prepared to present information on our steroids ARISTOCORT® Triamcinolone, as well as the diacetate and the acetone. Also Lederle pharmaceuticals and biologicals not frequently discussed in the doctor's office or in the hospital.

**Booth T-61**  
**MILLER PHARMACAL COMPANY**  
**West Chicago, Ill.**

Iron, magnesium, zinc, calcium, and manganese in complex forms designed to support the extra requirements of the body's hundreds of enzyme systems for minerals, vitamins, and amino acids during periods of stress and subnormal nutrition. Patients and physicians appreciate these products as an aid in — ALCOHOLISM - ARTHRITIS - DIABETES - HEART DISEASE - OSTEOPOROSIS - PREGNANCY. Impregnated Scarlet Red Gauze for burns and wounds.

**Booth T-63**  
**THE MEDICAL PROTECTIVE**  
**COMPANY**  
**Ft. Wayne, Ind.**

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim for damages based upon professional services rendered or which should have been rendered. Its experience from the successful handling of over 100,000 claims during 72 years of Professional Protection Exclusively is unparalleled in the professional liability field.



**Booth T-64**  
**UNITED MEDICAL**  
**LABORATORIES, INC.**  
**Portland, Ore.**

United Medical Laboratories offers the physician low-cost profile studies providing the potential for in-office multiphasic health screening. Profiles can improve patient care by augmenting history and physical exam, detecting pre-symptomatic phases of disease, making or confirming a diagnosis, and establishing patient normal biochemical base lines.

**Booth T-65**  
**ENDO LABORATORIES, INC.**  
**Garden City, N.Y.**

Endo Laboratories will present the latest clinical information relating to our products, COUMADIN® (SODIUM WARFARIN), NUMORPHAN® (OXYMORPHONE) HCL, PERCODAN®, PERCODAN®-DEMI, HYCOMINE®, HYCOMINE®-COMPOUND, HYCOMINE® PEDIATRIC, HYCODAN®, VALPIN® (ANISOTROPINE METHYLBROMIDE), VALPIN-PB (ANISOTROPINE METHYLBROMIDE WITH PHENOBARBITAL, PERCOGESIC®, PERCOGESIC®-C.

**Booth T-66**  
**ECKSTEIN BROS. INC.**  
**Hawthorne, Cal.**

Featured in Booth No. 66 are several screening and threshold audiometers all of which are of the latest all

solid state design. These instruments enable the physician to rapidly assess his patient's hearing response and for further diagnostic tests.

The Model EB-46 Tetra-tone audiometer is especially useful for rapid screening hearing tests. It is listed and approved by the American Academy of Ophthalmology and Otolaryngology.

**Booth T-67**  
**THE KAHLER CORPORATION**  
**Rochester, Minn.**

Three 4' by 8' photos. Artist sketch of The Kahler Hotel, Mayo Clinic Buildings, Methodist Hospital, and the pedestrian subway system connecting all units. A closed circuit TV showing same.

Two Kahler Corporation executives will be on hand at all times to answer questions and distribute brochures.

**Booth T-68**  
**PARKER, ALESHIRE & COMPANY**  
**Skokie, Illinois**

As the administrators of the officially sponsored group insurance programs for members of the ISMS, we invite you to stop at our booth and discuss these fine programs with our representative.

We have been privileged to administer your group disability plan since 1947, and your group major medical plan since 1958. A malpractice plan was approved in 1968.

The protection available is unexcelled, another benefit of your membership in the ISMS, and deserves your consideration.

*Eighth Annual*  
**Public Affairs Dinner**  
at the  
**Illinois State Medical Society**  
**Annual Meeting**  
**Monday**  
**May 17,**  
**Lower Jimmy Durante Room**  
**Arlington Park Towers Hotel**  
**Reception 6 p.m.**      **Dinner 7 p.m.**  
**\$13 per person**      **\$25 per couple**

# the peer reviewer

Council on Economics and Peer Review  
division of health care delivery

MARCH, 1971

THIS FIRST ISSUE OF -- "THE PEER REVIEWER" -- MARKS THE INITIAL ATTEMPT TO OPEN the lines of communication between County and District Peer Review Committees and the ISMS Council on Economics & Peer Review. Hopefully, members of peer review committees throughout the state will obtain information from this newsletter that will prove helpful in local peer review activities. It is also our intention to encourage local committees to report pertinent information to "THE PEER REVIEWER" which may prove helpful to other peer review committees in Illinois.

Peer review is becoming increasingly important and forms the base upon which future health care delivery systems will be built. I know we all agree this should be a strong base built by physicians. Peer review will insure that the quality and quantity of health care can be maintained at the lowest possible cost. We must all work together to achieve these objectives.

Glen E. Tomlinson, M.D., Chairman  
Council on Economics & Peer Review

PAYING PHYSICIANS FOR SERVING ON PEER REVIEW COMMITTEES HAS BEEN WIDELY DISCUSSED without apparently arriving at any conclusions. Some of the existing Foundations for Medical Care in the country do provide payment (about \$25 per-hour) for their peer review committees. Several commercial health insurance carriers have indicated a willingness to subsidize such local committees...at least pick up the tab for any expenses such as secretarial, postage, etc. However, a check with the Illinois Hospital Association reveals that hospital utilization review committees are generally looked upon as a voluntary group and therefore are not paid. Only a very limited number of Illinois hospitals pay for this service. What's the feeling of your Committee?

IMMUNITY LEGISLATION FOR PHYSICIANS ON PEER REVIEW COMMITTEES has been prepared by ISMS legal counsel and will soon be introduced in the Illinois House of Representatives. The proposed legislation will amend the Medical Practice Act to provide immunity for physicians serving on medical review and peer review committees in addition to those serving on medical utilization committees.



PSRO (PROFESSIONAL STANDARDS REVIEW ORGANIZATION) APPARENTLY WILL BE ADOPTED as part of new Medicare-Medicaid legislation (Bennett Amendment to HR 17550). Legislation to establish PSROs will be enacted by the end of April 1971, according to a prediction by Dr. Donald C. Harrington, president, American Association of Foundations for Medical Care. Dr. Harrington, who recently traveled throughout Illinois as an ISMS Consultant on the Foundation question, further predicted that January, 1972, will be the deadline for making PSROs operational.

Proponents of PSRO say it will prevent HEW control by allowing peers of local physicians to establish the review mechanisms to supervise the operations of Medicare and Medicaid in order to prevent abuse in the provision of services. Fees would not be a responsibility. (THUS, PEER REVIEW BECOMES THE HUB AROUND WHICH THESE GOVERNMENTAL PROGRAMS WILL REVOLVE.)

A CRITERIA FOR HEALTH CARE will soon be available from the Hennepin County (Minnesota) Health Care Foundation. These criteria, developed at great expense and effort by many physicians in the Minneapolis-St. Paul area, was developed to provide the standards for care under which the Health Care Foundation will negotiate with third party carriers. Perhaps these criteria can be adopted by Illinois physicians and give some helpful guidelines to local peer review committees. Copies can be obtained from your Illinois State Medical Society upon request.

AMERICAN MEDICAL ASSOCIATION HAS ANNOUNCED THE PUBLICATION OF a new drug compendium which will be distributed free to all AMA members. The 1,040 page guide covers more than 1,200 single entity drugs and mixtures, describing uses, adverse reactions, dosages, preparations and suppliers of each drug. The new publication --- title AMA Drug Evaluations --- was four years in preparation. This type of resourse material can prove helpful to local peer review committees.

### Reservation Form

**Illinois State Medical Society**  
**Annual Meeting**  
**May 16-19, 1971**

## ARLINGTON PARK TOWERS

Chicago's new suburban hotel  
Arlington Heights, Ill. 60006  
Telephone (312) 394-2000

A GULF + WESTERN HOTEL

Please reserve.....rooms(s) as checked for.....persons(s).

#### DAILY ROOM RATES

NAME .....

Please check preference:

SINGLE RATE ☐ \$20 ☐ \$22 ☐ \$24 ☐ \$26

(one person)

ADDRESS .....

DOUBLE RATE ☐ \$25 ☐ \$27 ☐ \$29 ☐ \$31

(two persons)

CITY and STATE .....

(Zip, please)

Additional persons 12 years or over—\$5 per person.

Children under 12 sharing room—Free.

FIRM .....

EXECUTIVE ☐ \$40 ☐ \$45 ☐ \$50

SUITE

(combination living room/bedroom)

(I) (We) will arrive on ..... at.....  
(day) (date) (time)

LIVING ROOM/ ☐ \$65 ☐ \$67 ☐ \$70 ☐ \$81

BEDROOM SUITE

(I) (We) will depart on ..... at.....  
(day) (date) (time)

Larger suite rates on request.

Reservations will be held until 6 p.m.

NOTE: If room is not available at rate requested, reservation will be made at nearest available rate.



## editorials

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### Is the practice of medicine a monopoly?

Organized medicine is not a monopoly although many people may think so. We cannot prevent laymen from consulting osteopaths, chiropractors, or even witch doctors. Anyone can go into a drugstore and get medication from the pharmacist. We abhor standard fees even though encouraged to do so by government agencies. Many communities appear to have set fees for office visits, housecalls, tonsillectomies and delivering babies, but these were not established through collusion. We may recommend that "bad apples" in the medical barrel be removed, but a medical society is powerless in this regard because the state provides the license to practice.

Several years ago a British governmental agency (Board of Trade) requested the Monopolies Commission to report on restrictive practices affecting professional services. This was not an easy task because a marked difference exists between professional practices and commercial organizations with their trading monopolies. When the task was completed, the investigators had very little to offer although the inference was, "It smells of a monopoly but we cannot see it." They reported that only registered medical practitioners may sign death certificates or perform

other functions. In addition, deprivation of a medical title was virtually sufficient to keep men out who were unqualified. The commission apparently refused to recognize the care provided by psychologists and unregistered practitioners of many kinds whose practices flourished throughout the country.

Lawmakers find it difficult to understand the differences between restrictive practices for personal profit and for the patient's benefit. This was true of the Commission. They could not determine how far the practices of particular professions are justifiable even though they made no attempt to probe the question. In our country, as in England, the neophyte physician knows the relationship between doctor and patient, and between one doctor and another. He also knows the restrictions imposed by the state. But above all, physicians realize that public confidence in the medical fraternity is built upon the knowledge that the physician will not abuse the trust placed in him. Outsiders do not realize that these professional privileges are provided to protect the rights of the patient and not the doctor.

T. R. Van Dellen, M.D.

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#### **How NOT to solve social problems**

"We have or should have learned that it is easier to articulate problem dimensions than problem solutions. It's too easy to fall prey to the 'Washington syndrome'—the simple-minded theory that social problems will just disappear if the Federal Government throws enough dollars and statute books at them. And we should also have learned that the cruel and exaggerated rhetoric of unkept promises can threaten the very credibility of government itself." —HEW Secretary Elliot L. Richardson.





# Empirin<sup>®</sup> Compound with Codeine, gr. 1/2 or gr. 1

## Helps overpower pain

Each tablet contains: aspirin gr. 3½,  
phenacetin gr. 2½, caffeine gr. ½.

No. 3 contains codeine phosphate\* (32.4 mg.) gr. ½.

No. 4 contains codeine phosphate\* (64.8 mg.) gr. 1.

\*(Warning—may be habit forming.)

B. W. Co. narcotic products are Class "B," and as such are  
available on oral prescription, where State law permits.

Complete literature available on request from Professional  
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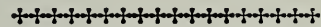


# socio-economic news

a service of the division of health care delivery

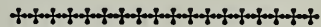
## **Special House Session Ordered**

A special meeting of the ISMS House of Delegates will be held May 15, 1971, to consider the establishment of a Foundation for Medical Care in Illinois. ISMS Board members approved the special session, at which only the Foundation issue will be discussed, because of the importance given this subject. The Board felt Delegates should consider Foundations separately from the regular order of convention business which begins May 16. At the special session, Delegates will decide if ISMS should support FMCs, at what level (county, regional or statewide) should FMCs be established, and what programs should the Foundations encompass (Medicare, Medicaid, private health insurance). Trustees also requested an educational program on Foundations be conducted prior to May 15, in those Districts whose Delegates have not had previous exposure to this complex question.



## **Many Changes Being Planned**

DeKalb, Freeport, Quincy, Lincoln, Chicago, Mt. Vernon, McHenry and Springfield have been making the news in their areas, recently, with various programs for changing health care delivery. Plans range from free clinics (Freeport and Chicago) to experimental programs requesting HEW funds (DeKalb, Springfield, East St. Louis and Chicago) to hospital-based closed panel programs such as Lincoln, Quincy, McHenry and Chicago. All profess to be an improvement over the existing system. Some are supported by the county medical society, some have caused a split among society members. In these cases and others that may develop in the months ahead, the county medical society should carefully examine all the facts. The county medical society should have answers to such important questions as: who determines the quality and quantity of care?; who reviews disputes involving physicians?; what is the relationship between physicians and hospital boards of director?



## **An Experiment In Prepayment**

A cooperative prepaid group practice experiment, involving the Carbondale Clinic (24 physicians), the Doctors Memorial Hospital of Carbondale, and Blue Shield-Blue Cross, opened for business in mid-February. Using funds from the Model Cities program, the prepaid clinic will provide physician and hospital care to 55 disadvantaged families (expansion to 100 families is expected) in the Carbondale area. A broad range of health care services, including



complete out-patient care, well-baby care, prescription drugs, emergency treatment and all in-hospital care are included in the program.

All but nine of the 55 families in the program have selected Carbondale Clinic physicians who will be paid on a capitation basis by Blue Shield. Physicians treating the remaining nine families will be paid on a fee for service basis.

Funding from Model Cities will continue through next August. Blue Shield said it was interested in possible participation in similar prepaid programs in other areas of the state. The company told ISMS, discussions were already underway with several such groups. More specific information was not offered because "these discussions were still in the very early stages," according to Blue Shield.

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## **PSROs by '72**

Legislation to establish Professional Standards Review Organizations (PSRO) will be enacted by the end of April 1971, according to a prediction by Dr. Donald C. Harrington, president, American Association of Foundations for Medical Care. Dr. Harrington, who recently traveled throughout Illinois as an ISMS Consultant on the Foundation question, further predicted that January, 1972, will be the deadline for making PSROs operational. Dr. Harrington's opinion on the PSRO concept (in which local physicians assume the responsibility for the review of, but not the payment of services) is contrary to President Nixon's proposal encouraging development of Health Maintenance Organizations (HMO).

Administration spokesmen said the present goal calls for establishing 100 new HMOs in 1972, and another 100 shortly thereafter. Enrollment of 90% of the population in HMOs is expected by 1980. Dr. Harrington thinks the HMO concept is presently meeting strong opposition in Congress and will be defeated. His objections to HMOs include: HEW's demand that they be competitive; and, that all eligible persons in the HMO area be contacted and offered participation in the program.

\*\*\*\*\*

## **Peer Review Can Control Malpractice**

Peer review of physicians' services is a vital step toward easing the malpractice crisis, according to Robert C. Lukens, an officer of the Hartford Insurance Group, a major carrier of malpractice insurance. Lukens said the solution of the malpractice insurance problem must start with doctors realizing that there is a malpractice problem . . . not just a malpractice insurance problem. He said "the crisis arises from a deteriorating doctor-patient relationship, extraordinary jury awards for commonplace injuries, contingency-fee practices in our legal system, mounting public sophistication in medicine coupled with unhappiness over medical fees, and the resultant inability of insurance companies to write malpractice insurance at a profit.

"MDs must support some of the new ideas advanced to help control the cost of malpractice insurance," Lukens

*(Continued on page 444)*

## Halotestin® (fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.

**Indications** *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

**Contraindications** Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

**Precautions** Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

**Adverse reactions** Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

**Supplied Tablets:** 2 mg., scored—bottles of 100./5 mg., scored—bottles of 50./10 mg., scored—bottles of 50.

For additional product information, see your Upjohn representative or consult the package circular.

**Upjohn** The Upjohn Company, Kalamazoo, Michigan

JAGB-7627-R

MED 8-5-S (LQR)

## SAM, the computer a friend to physicians

A county medical society official sees a friendly computer in the future of the nation's doctors. The computer, he says, will almost surely save them time and money while providing machine-like accuracy.

Harry A. Lehman, executive secretary of the Jefferson County Medical Society, Louisville, Ky., says his group has been successfully using a computer called SAM (Systematic Accounts Management) for a number of years.

Here's what he told a gathering of health insurance and medical men attending the Health Insurance Council's conference on effective utilization of health care facilities and services, held in Chicago.

"Sam works exclusively for physicians and hospitals. He takes over the time consuming job of patient billing; he furnishes up-to-date, meaningful reports on the doctor's practice; he can increase the collection recovery and establish systematic procedures. He can do all of this at less than the doctor's present cost.

"SAM is young and not tremendously successful yet, but we have a bright picture in our mind for SAM. . . . We believe that true accounting will show that the average doctor spends from 50 to 80 cents on the average statement. SAM's charge is 30 cents plus postage.

"We believe SAM is an adaptable, flexible system which will provide good service and economy for the doctor. In addition to the stuffing, addressing, mailing, insertion of additional items, aging of accounts, collection reminders and so forth, SAM will provide and does provide a weekly journal, a monthly age account analysis, a monthly practice analysis, and year-to-date account journal.

"We are now seriously considering SAM's role in peer review, as well as a medical foundation which can handle the payment of claims."



# Socio-economic news

(Continued from page 440)

said. Among new approaches worthy of consideration he cited: "patients agreeing to arbitration of any legal claim or civil action as a condition for hospital admission; no-fault insurance to cover patients by a 'medical accident policy' with a schedule of benefits for various injuries; and legislation limiting the time during which a claim could be made following the date of injury."

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## *Clinics for physically handicapped scheduled in May*

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will hold 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- May 4 Pittsfield—Illini Community Hospital
- May 4 Fairfield—Fairfield Memorial Hospital
- May 4 East St. Louis—Christian Welfare Hospital
- May 5 Hinsdale—Hinsdale Sanitarium
- May 6 Sterling—Community General Hospital
- May 6 Effingham—St. Anthony Memorial Hospital
- May 6 West Frankfort — UMWA Union Hospital
- May 6 Litchfield—Madison Park School
- May 11 East St. Louis—Christian Welfare Hospital
- May 11 Peoria—St. Francis Children's Hospital
- May 12 Champaign-Urbana—McKinley Hospital
- May 12 Joliet—St. Joseph's Hospital
- May 13 Springfield—St. John's Hospital
- May 13 Macomb—McDonough District Hospital

- May 14 Chicago Heights Cardiac—St. James Hospital
- May 18 Rock Island Area General—Moline Public Hospital
- May 19 Evergreen Park—Little Company of Mary Hospital
- May 20 Decatur—Decatur Memorial Hospital
- May 20 Elmhurst Cardiac—Memorial Hospital of DuPage County
- May 25 Peoria—St. Francis Children's Hospital
- May 26 Springfield Pediatric Neurological—Diocesan Center
- May 26 Centralia—St. Mary's Hospital
- May 26 Elgin—Sherman Hospital
- May 27 Rockford—Rockford Memorial Hospital
- May 28 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# what goes on

## a guide to continuing education

### April 23-24—The American Geriatrics Society

#### 28th Annual Scientific Meeting

The two days of scientific sessions will include symposia on sexual activity in aging men and women and on industrial, home and auto accidents among the elderly. Authorities on geriatric diseases and on metabolic diseases will also take part in a panel discussion on the treatment of diabetes with oral drugs and insulin. Individual scientific research reports will be on therapy for parkinsonism, coronary artery surgery, chronic peptic ulcer disease and the prevention of atherosclerosis. Other special reports will be on aging skin problems and diseases of the gastrointestinal system associated with aging.

Ambassador Hotel, Chicago

### April 25—American Medical Association

#### Conference on Long-Term Care

Edward J. Lorenze, M.D., Medical Problems of the Long-Term Patient  
John F. Briggs, M.D., Problems of Old Age and Role of the Nursing Home  
Louis N. Katz, M.D., Need for Long-Term Care for Patients with Atherosclerosis  
Irving S. Wright, M.D., Prevention and Treatment of Atherothrombosis  
Clark H. Millikan, M.D., Diagnosis of Occlusive Cerebrovascular Disease  
Mark L. Dyken, M.D., Modern Treatment of Occlusive Cerebrovascular Disease  
Pierre Salmon, M.D., Interdisciplinary Teamwork in the Long-Term Care Facility  
Jack Kleh, M.D., Physician's Role

Mrs. Barbara A. Davis, R.N., Nurse's Role  
Edward Walker, R.Ph., Pharmacist's Role  
Hobart Jackson, M.S.S., Social Worker's Role  
Mrs. Eleanor B. Baird, Administrator's Role

The purpose of the conference is to emphasize the CHALLENGE to the practice of medicine presented by patients in long-term care facilities, to discuss medical problems of the long-term patient and to suggest optimum methods for treatment, to point out the effectiveness of physician leadership and support to a multidisciplinary team.

Drake Hotel, Chicago

### April 26-28—Health Industries Association, Mid-American Nursing Home Association, Tri-State Hospital Assembly

#### Great Lakes Health Congress

General educational sessions and departmental conference have been designed to meet the mutual needs of personnel from both hospitals and nursing homes. These stimulating programs will reflect the interests of such diverse but related health care groups as those representing home health, rehabilitation, planning agencies, public health, architects, consultants and allied fields.

McCormick Place, Chicago

### April 27-29—IIT Research Institute

#### 4th Annual Scanning Electron Microscope Symposium

Over 65 papers consisting of comprehensive reviews and discussion of recent SEM developments in instrumentation and applications are scheduled. Some of the invited papers will emphasize specimen preparation, result interpretation and quantitative information from the SEM.

Sessions on biological, medical, dynamic, and semiconductor applications; materials characterization; instrumentation, analytical techniques and crystallographic information are planned.

Subjects of high current interest include the hazards of organochlorine insecticides (such as DDT) on eggshells; the characterization of respirable mine dusts; the identification of physical and biochemical properties of human hair; a study of chronic pulmonary emphysema; and the examination of biological materials at low temperatures.

Also to be discussed are dynamic studies of deformation mechanisms; Auger electron spectroscopy for scanning electron microscopy; metal fatigue mechanism studies; characterization of metals in lunar soil; and device fabrication in the SEM.

Illinois Institute of Technology, 10 W. 35th Str., Chicago

### April 30—IIT Research Institute Workshop

#### *"Forensic Applications of the Scanning Electron Microscope"*

Presentations at the workshop will include discus-



sions of SEM fundamentals and analytical techniques, and invited papers on various aspects of SEM applications in forensic sciences. The session is planned to achieve a thorough discussion of the usefulness of the SEM in diversified problems encountered by forensic scientists.

Illinois Institute of Technology, 10 W. 35th Str., Chicago

#### **April 28—University of Illinois College of Medicine**

28th Annual D. J. Davis Memorial Lecture on Medical History

The lecturer is Dr. Harry F. Dowling, Professor Emeritus and former Head, Department of Medicine, University of Illinois College of Medicine. The title of the lecture will be "Frustration and Foundation: The Management of Pneumonia Before the Antibiotics."

1853 W. Polk Str., Chicago

#### **April 28-30—Chicago Heart Association Workshop**

*"Nutrition in Heart Disease Prevention and Therapy"*

Chicago Heart Association, 22 W. Madison Str., Chicago

#### **April 29-30—Illinois Heart Association Scientific Session**

*"Coronary Care in the '70s"*

James V. Warren, M.D., General Organization of Coronary Care Units

Adeline C. Jenkins, R.N., Initial and Ongoing Training of Nurses and Paramedical Personnel

John Kimball, M.D., What Modalities are Monitored and How

Catherine Baden, R.N., Changing Function of Nurses in Coronary Care Units

Jeb Boswell, M.D., Electrical Hazards in Coronary Care Units

James V. Warren, M.D., The Future of Coronary Care

Sylvan Weinberg, M.D., Cardioversion and Pacing

Rolf Gunnar, M.D., Drugs in Coronary Care Units

Holiday Inn East, Springfield

#### **May 1-6—American College of Obstetricians and Gynecologists**

19th Annual Meeting

Postgraduate and Clinical Programs

The program will develop three themes, Perinatology, Pelvic Infections, and Diseases of the Vulva, one each day. The general sessions, seminars, correlated seminars, round tables and reports on clinical investigations will each relate to the day's theme.

San Francisco Hilton Hotel, San Francisco, California

#### **May 5-8—American College of Surgeons**

15th Annual Postgraduate Course on Fractures and Other Trauma

Abdominal injuries, respiratory problems, head and facial injuries, vascular complications, brain injury, and shock will be covered, along with musculoskeletal trauma. There will be symposiums on spine injuries and knee problems. Thirty-three men will compose the faculty and will represent all of the medical schools in the Chicago area.

John B. Murphy Auditorium, 50 E. Erie Str., Chicago

#### **May 16-19—Illinois State Medical Society 131st Annual Meeting**

See Delegates Handbook for further information

Arlington Park Towers, Arlington Park, Illinois

#### **May 17-18—Rehabilitation Institute of Chicago**

Postgraduate Course

"Recent Advances in Neuromuscular Disorders: Diagnosis and Rehabilitation" is being conducted by Research and Training Center #20 of the Rehabilitation Institute of Chicago and the Department of Rehabilitation Medicine, Northwestern University. This course is designed for physicians and allied health professionals interested in the diagnosis, rehabilitation and management of neuromuscular disorders.

Well-known neurologists and physiatrists make-up the faculty which includes: Dr. Henry B. Betts, medical director and vice president of the Rehabilitation Institute; Dr. Richard Hermann, Temple University; Dr. W. King Engel, National Institute of Health; Dr. Benjamin Boshes, chairman, Department of Neurology, Northwestern University; Dr. Ernest Johnson, Ohio State University.

Offield Auditorium, Passavant Hospital, Chicago

#### **May 17-19—American Cancer Society 2nd National Conference on Breast Cancer**

"Newer Concepts in Management, Incidence and Mortality, High Risk Groups, the Pill, Viruses"

"Immunology, Cell Kinetics, Genetics, Animal Experimentation, Early Breast Cancer"

"Detection, Screening"

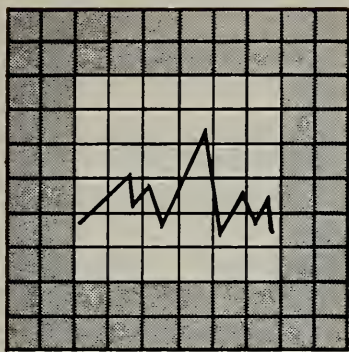
"Management of Primary Operable Breast Cancer"

"Rehabilitation"

The Conference will present a multidisciplinary review of the breast cancer problem in the United States including epidemiology, etiology, detection, diagnosis and management.

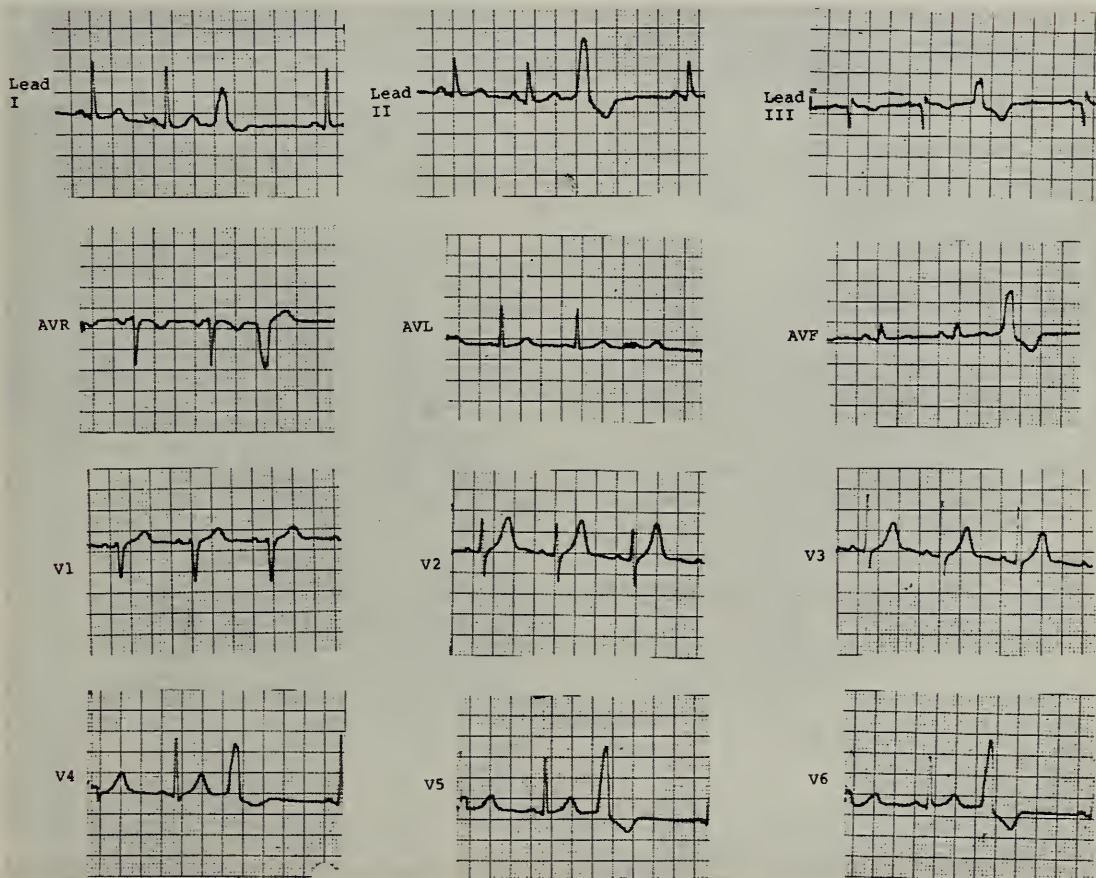
Century Plaza Hotel, Los Angeles, California

(Save for reference)



# ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RINGAUDAS NEMICKAS,  
M.D. AND PATRICK SCANLON, M.D./SECTION OF CARDIOLOGY,  
DEPARTMENT OF MEDICINE  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



A fifty-six year old white male is seen complaining of palpitation. He gives a history of having had a "heart attack" three years previously. Physical examination disclosed a radial pulse rate of 82 with frequent "dropped" beats. The B/P was 115/80. A pulse wave (A) was noted in the jugular veins with "dropped" beats. Palpation of the precordium was not remarkable. The left heart border was in the 5th intercostal space and the mid-clavicular line. Auscultation disclosed an  $S_4$  (atrial gallop) at the apex and ectopic

beats. Examination was otherwise unremarkable.

**Questions:** (One or more of the choices presented may be correct.)

The electrocardiogram demonstrated:

1. Premature atrial beats
2. Inferior wall infarction, not recent
3. Premature ventricular beats
4. Lateral wall infarct, not recent
5. Premature ventricular beats, arising from right ventricle

(Answer on page 456)





# new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Products**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## New Single Chemical Entity

**VERSAPEN** Penicillin & Deriv. R

**Manufacturer:** Bristol

**Nonproprietary name:** Hetacillin

**Indications:** Susceptible strains of gram-negative and gram positive bacteria

**Contraindications:** Hypersensitivity reaction to any of the penicillins

**Dosage:** Mild to moderate infections: Patients over 90 lbs.: 225 mg. q.i.d. Patients under 90 lbs.: 2.5 mg./lb. q.i.d.

More severe infections: Patients over 90 lbs.: 450 mg. q.i.d. Patients under 90 lbs.: 5 mg./lb. q.i.d.

**Supplied:** Chewable tablets, equivalent to 112.5 mg. ampicillin

**VERSAPEN-K** Penicillin & Deriv. R

**Manufacturer:** Bristol

**Nonproprietary name:** Hetacillin potassium (USAN)

**Indications:** Susceptible strains of gram-negative and gram-positive bacteria

**Contraindications:** Hypersensitivity reactions to any of the penicillins

**Dosage:** Mild to moderate infections: Patients over 90 lbs.: 225 mg. q.i.d. Patients under 90 lbs.: 2.5 mg./lb. q.i.d.

More severe infections: Patients over 90 lbs.: 450 mg. q.i.d. Patients under 90 lbs.: 5 mg./lb. q.i.d.

**Supplied:** Capsules, equivalent to 225 or 450 mg. ampicillin

## Combination Products

### TABRON

**Filmseal Hematinic-Vitamin Combination** R

**Manufacturer:** Parke Davis

Composition: Ascorbic acid	500 mg.
Thiamine mononitrate	6 mg.
Riboflavin	6 mg.
Pyridoxine HCl	5 mg.
Cyanocobalamin, crystalline	25 mcg.
Folic acid	1 mg.
Niacinamide	30 mg.
Calcium pantothenate	10 mg.
Vitamin E	30 I.U.
Iron (ferrous fumarate)	100 mg.
Diocetyl sodium sulfosuccinate	50 mg.

**Indications:** Iron deficiency anemia and folate deficiency

**Contraindications:** None mentioned

**Dosage:** One Filmseal daily

**Supplied:** Filmseals

## New Dosage Forms

**VERSAPEN** Penicillin & Deriv. R

**Nonproprietary name:** Hetacillin

**Indications:** Susceptible strains of gram-negative and gram-positive bacteria

**Contraindications:** Hypersensitivity reactions to any of the penicillins

**Dosage:** Mild to moderate infections: Patients over 90 lbs.: 225 mg. q.i.d. Patients under 90 lbs.: 2.5 mg./lb. q.i.d.

More severe infections: Patients over 90 lbs.: 450 mg. q.i.d. Patients under 90 lbs.: 5 mg./lb. q.i.d.

**Supplied:** Oral suspension:

Each 5 cc. reconstituted suspension equivalent to 112.5 mg. ampicillin

**VERSAPEN** Penicillin & Deriv. R

**Manufacturer:** Bristol

**Nonproprietary name:** Hetacillin

**Indications:** Susceptible strains of gram-negative and gram-positive bacteria

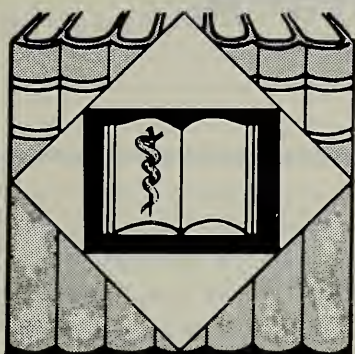
**Contraindications:** Hypersensitivity to any of the penicillins

**Dosage:** Mild to moderate infections: Patients over 90 lbs.: 225 mg. q.i.d. Patients under 90 lbs.: 2.5 mg./lb. q.i.d.

More severe infections: Patients over 90 lbs.: 450 mg. q.i.d. Patients under 90 lbs.: 5 mg./lb. q.i.d.

**Supplied:** Pediatric drops:

Each cc. reconstituted solution equivalent to 112.5 mg. ampicillin



## the doctors library

### **Perspectives in Community Mental Health.**

Edited by Arthur J. Bindman and Allen D. Spiegel. Aldine Publishing Co., Chicago, 1969, 718 pages.

This is a collection of fifty-five papers in community psychiatry published during the 1950's and 1960's gathered from various journals by Drs. Bindman and Spiegel to form "... a practical compendium designed for use by a wide variety of mental health professionals and non-professionals." The dust jacket goes on to characterize the book as presenting many differing theoretical viewpoints, and "... a wealth of innovative approaches to mental health needs make this book the most comprehensive available."

The selections are organized under six major headings ranging from the meaning of community mental health through elements of planning and development techniques and methods, the location and physical plant, roles of professional mental health workers, and research and evaluation.

I found the selected papers to be of varying quality and interest. Some, such as H. Warren Dunham's "Community Psychiatry, the Newest Therapeutic Bandwagon," and Benjamin Pasanick's "The Development of Physicians for Public Mental Health" were absorbing and provocative, while others such as "The Impact of the New Federal Mental Health Legislation on the State Mental Health System" by Bertram S. Brown were dryly written but interesting. In addition, there were quite a few selections covering such specialized topics as health care financ-

ing, architecture, and aging. There were also a few selections whose importance did not seem to merit being included in a volume purporting to contain a general review of the field. One such would be Glenn V. Ramsey's "Sociotherapeutic Camping for the Mentally Ill."

When attempting to read a book such as this, the reader is confronted with a variety of styles and orientations, which, of course were the editors' intentions. This variety, however, limits the book's usefulness as an introduction for a mental health professional because of the absence of a true unifying theme. This absence is compensated for somewhat by the editors' organization of the material into the six categories, but this cannot take the place of a single viewpoint which a text by a single author or group of authors would bring. It may be argued that this single viewpoint is just what the editors sought to avoid, and that the scattered nature of the material faithfully reflects the true nature of the field of community psychiatry.

For those with greater interest and time available, this book can be a rewarding experience. The editors seemed to succeed in their aim of presenting variegated points of view and there is quite a large amount of information.

Perhaps the best use for this comprehensive volume is as a reference; and, I feel it is a good one. The index seems usable and the bibliographies of many of the papers seem quite extensive.

I would recommend this volume for the shelf of any mental health professional with a major interest in community psychiatry.

Ronald Abramson, M.D.





## practice management

While the preparation of insurance forms is certainly not new to the average medical practice, in my consulting with doctors and their aides on the business side of practice, I still find confusion regarding insurance forms. Much confusion stems from the lack of a well-defined relationship between the trinity of doctor, patient and insurance companies. The doctor must decide whether the insurance company or the patient is primarily responsible for the bill. Obviously when the doctor accepts a known aid patient or always takes assignments on Medicare patients, he is looking to the third party rather than the patient for the entire payment of his bill. This situation is clear. But when a patient, backed by private insurance, avails himself of the

of account. It establishes with the patient the principle that you hold him primarily responsible for the bill. As a courtesy to the patient and to eliminate unnecessary phone calls you might designate on the bill the date this insurance form was submitted or you might merely rubber stamp on the bill "Insurance Pending."

*Should a doctor insist on an assignment of benefits to himself?* Yes. Your primary purpose in filling out the form is to augment your own collections. Completion of a patient's form without at least sharing in the proceeds defeats your purpose in filling out the form and negates his original objective in purchasing the insurance. Therefore, even if his insurance company may not honor the assignment, educate the patient by

### *The problem of insurance forms*

BY ROBERT P. REVENAUGH/PROFESSIONAL BUSINESS MANAGEMENT, INC.

doctor's services, what is the proper relationship between patient, doctor, and the insurer? I submit that the doctor should hold the patient completely responsible for the payment of the bill. The patient should be advised accordingly because in many instances he believes that the insurance purchased will fully satisfy the doctor bill. The privity exists between doctor and patient, not between doctor and the patient's insurance company. The patient should be informed that the doctor's office will properly complete insurance forms but that the primary responsibility for payment of the bill rests with him. With this philosophy in mind the answers to these commonly asked questions is easier.

*Should a doctor's office bill a patient if an insurance form has been submitted and insurance proceedings are pending?* The answer is yes. A bill is not a demand for payment but a statement

having him authorize it anyway.

*Should a doctor's aide be involved with pursuing patients' insurance claims?* No. Again the privity exists between the patient and his insurance company. You should be following up the insurance company. By entering into the relationship between patient and his insurance company you are impliedly consenting to wait for insurance proceeds to satisfy the bill.

*Should a doctor's office charge for processing insurance forms?* Not unless the proceeds to the patient will exceed his total bill. If, for example, a patient with numerous insurance policies will profit from his illness, I feel you are justified in charging him for the extra administrative services performed.

Other questions usually refer to a system for processing insurance forms. We suggest that you have an insurance log. When someone submits

a form to you, log it in and indicate the date received. When you finish it, indicate on the log the date mailed. At this point you should also make a similar notation on the patient's account card. When an insurance check is received, note the insurance company as well as the patient's name on the daily log or day sheets. When you post the credit to the patient's account card also note the company making the payment. Noting the paying insurance company's name on the day sheet is important for tax purposes. Medical insurance companies submit yearly reports to the IRS indicating yearly payments to the doctor. The doctor may be called on to prove how much he in fact received from various insurance companies and to show that he paid tax on these amounts. Noting the receipts aids in tracing in the event of audits as many doctors have recently experienced regarding Medicare payments. Properly noting insurance payments on the patient's account card provides a better credit evaluation of the patient.

For tax and other reasons we do not advise our clients to endorse insurance checks over to patients. Deposit all checks received. If a large insurance payment results in a credit balance on a patient's account card, reimburse him with your own check. Again, the insurance companies will report to the government the amount of money paid to the doctor as determined only by whose name appears on the check.

In my experience, many doctors fail to realize that typing an insurance form is a relatively easy chore. Use of the standardized insurance form has made it even easier. Problems often arise, however, in obtaining the information to put in the blanks. In most cases it seems that either the records are incomplete or the secretary cannot read the doctor's handwriting.

Although some of you may disagree, filling out insurance forms is good business. Even after considering the additional clerical costs, doctors are now recovering a higher percentage of the amounts owed to them by patients than they did before insurance.



## public affairs

a service of the division of legislation and public affairs

### *Nixon and Rumsfeld to appear at ISMS Washington Round-up*

President Richard Nixon will be the featured speaker at the Annual U.S. Chamber of Commerce meeting, held in conjunction with the annual ISMS Washington Round-up in Washington, April 25-28.

A special day will be set aside during the joint meeting, April 28, giving ISMS members an opportunity to meet with Presidential Councilor Donald Rumsfeld, and former OEO director.

The four-day affair will be devoted exclusively to medical developments at the national level.

Watch for the day-by-day agenda in the April issue of *Pulse*.

For additional information, contact the Division of Legislation and Public Affairs, ISMS, 360 N. Michigan Ave., Chicago, 60601.



# Health care delivery crisis

(Continued from page 350)

paid health insurance before the government does.<sup>9</sup>

California, as already stated, has 16 foundation type plans and the snowball is rolling throughout the U.S.

Recently, Chairman Russell Long (D-Ala.) of the Senate Finance Committee proposed "a plan to provide government sponsored major medical insurance for all Americans under 65 who pay Social Security taxes."<sup>10</sup> This catastrophic type of insurance is gaining prominence and has bipartisan support. It seems likely to be included in future national health plans although it may prove to be a delaying move or even a substitute.

Consider what has happened in Quebec, Canada, since October to our fellow physicians who resisted governmental intervention. "Under the terms of the Canadian bill #41, the 3700 members of the Federation of Medical Specialists of Quebec are prohibited from absenting themselves from their normal practice circumstances under penalty of \$500 daily fine and a month imprisonment. Further, the government would have the authority to impound the prop-

erty and assets of any physician who leaves the province in defiance of the law."<sup>11</sup>

Serious reservations and questions about our nation's early struggles to revise the health care delivery system, or non system as some call it, exist.

Will comprehensive programs really work? Will the H.M.O. concept result in cost saving? Will quality of care suffer by putting a premium on economy? These and many other questions must be answered, preferably by experimental group trials, before attempting full implementation on a national scale.

It appears that, whether we like it or not, medicine has reached the crossroads of change in health care delivery. Some form of prepaid care for all, possibly with catastrophic health insurance is coming. Costs are skyrocketing, pressures from the public, the press, the unions and government are closing in upon us and leaving very little choice.

Governmental intervention and control must be avoided. Physicians must become better informed and willing to act to

prevent non-professionals from squeezing the physician out of medicine and depriving the public of the best quality medical care for alleged economy.

We urgently need plans that will utilize the free-enterprise system which will control cost, quality and utilization in the best interests of the patient and physician to the benefit of our entire nation.

## References

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5. *AMA News*, September 28, 1970.
6. *AMA News*, September 28, 1970.
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10. *AMA News*, November 30, 1970.
11. *ACR Bulletin*, November, 1970.

## Physicians' Placement Service lists openings

**SHELBY COUNTY:** Cowden; population: 600. Six small towns in area without physicians. Equipped office available. Nearest physicians 15 miles. Nearest hospitals at Shelbyville and Effingham. Agricultural area with light industry. Four Protestant churches. Grade and high schools. Nearby golf course. For further information contact: Mr. Herschel M. Cosart, Cowden.

**WHITESIDE COUNTY:** Fulton, Ill. and Clinton, Ia. Trade area: 80,000. Openings in internal medicine, ophthalmology, orthopedics,

pediatrics and general practice at Medical Associates, a group of 14 operating offices in Fulton, Ill. or Clinton, Ia. Group established in 1960. Percentage basis, guaranteed income; no investment necessary; opportunity for partnership. New modern facility. Twenty-eight physicians in community. Two hospitals; 450 beds. Two 18-hole golf courses. Excellent recreation area. Good schools and churches. For further information contact: Elvin Norman, Clinic Manager, Clinton, Ia. Phone: 319-243-2511.

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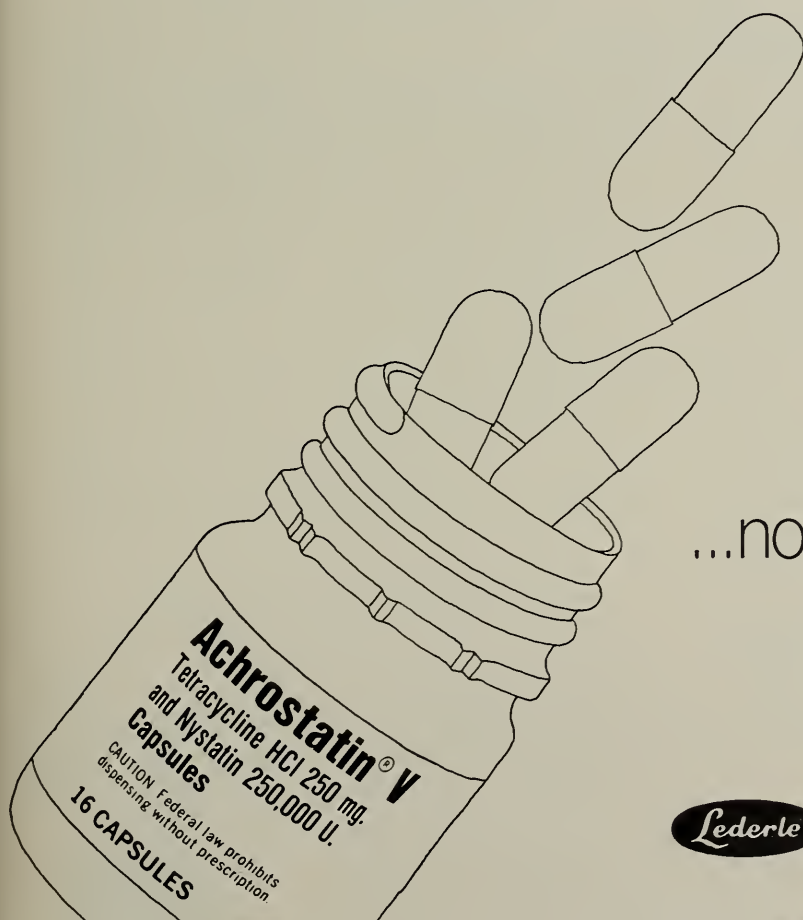
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## **Viewbox**

*(Continued from page 341)*

**DIAGNOSIS:** Osteoblastic metastatic disease from a carcinoma of the prostate which has been treated with estrogens. The listed conditions are only several of the numerous causes of increased bony density. In a patient of this age group, the most likely lesion is a carcinoma of the prostate with dense, osteoblastic metastases. The most frequent metastatic lesion in males which cause osteoblastic metastatic lesions arise from the prostate. Other metastatic osteoblastic foci are male breast tumors, lymphoma, and other unusual primary sites (such as stomach, colon and pancreas) which will cause osteoblastic metastases.

An incidental finding is the presence of gynecomastia which gives us a hint that this patient has been receiving estrogen therapy for metastases that are known to be from the prostate. Also noted is aneurysmal dilatation of the thoracic aorta.

## **EKG**

*(Continued from page 447)*

### **Answers:**

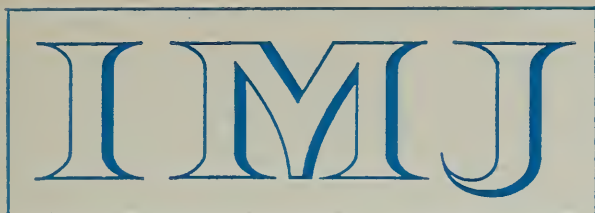
2. Inferior wall infarct, not recent. The frontal plane QRS axis is  $+15^\circ$ . A Q wave is present in II, III, and AVF. The Q in III measures 6 mm and 0.04 sec. duration. The ST-T segments and T waves in these leads do not suggest recent infarction.
5. Ectopic Beats are seen in Leads I, II, III, AVR, AVF,  $V_{4-6}$ . No P wave precedes these complexes and their QRSs are over 0.12 sec. in duration. The premature beats are coupled; the interval between the preceding normal R waves and the PVBs is constant. The configuration of the PVBs in Leads I and  $V_6$  resembles those seen in left bundle branch block and thus, suggests they arise in the Rt. ventricle.

---

Some get behind for months, instead.  
Some do their best; some build, some make.  
Some never do—just sit and take.  
Some lag behind, just let things go,  
And never help their group to grow.  
Some drag, some pull. Some don't, some do.  
Consider: Which of these are you?

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One sign of the times is that necessities have become luxurious and luxuries too necessary. Our term for it is "inflation."



# illinois medical journal

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May, 1971

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Abstracts of Board actions .....	477
----------------------------------	-----

clinical  
articles

The patent omphalomesenteric duct <i>Crile Doscher, M.D.</i> .....	493
Management of the patient with terminal illness <i>J. Ernest Breed, M.D./ISMS President</i> .....	503
Monitoring of Intrathecal Polymyxin B Dosage during treatment of pseudomonas meningitis <i>Warren Furey, M.D., Ivan Ciric, M.D. and Richard H. Parker, M.D.</i> .....	507
Gardner's Syndrome <i>Mohammad Yousuf Aleem, M.D.</i> .....	511

special article	Alcoholic Treatment: The Group Experience <i>Richard S. Cook, M.D.</i> .....	514
--------------------	---	-----

surgical grand rounds	Carcinoma in perforated diverticulum of the colon .....	498
--------------------------	---	-----

features	the presidents page .....	474
	ekg of the month .....	497
	the viewbox .....	502
	new pharmaceutical specialties .....	521
	clinics for handicapped children .....	523
	the doctors library .....	524
	obituaries .....	526
	editorials .....	534
	imaa report .....	536
	socio-economic news .....	541
what goes on .....	545	
practice management .....	556	

(Cover story on page 526)

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



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# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### MORTON W. ADLER, M.D. NEW BCBS MEDICAL DIRECTOR

The Illinois Medical Service and the Hospital Service Corporation announce the election of Morton W. Adler, M.D. as vice-president and medical director of the Blue Cross Blue Shield Plans. Dr. Adler was elected by the Plans' Board of Trustees to fill the post vacated by John C. Troxel, M.D. who retired on December 31.

As head of the Medical Division, the department, which offers support and consultation to all divisions of Blue Cross and Blue Shield and which is responsible for the services provided by our employees' clinic, Dr. Adler is responsible for establishing medical policy and assisting in the adjudication of claims. He also acts as a liaison between Blue Cross and Blue Shield, physicians and providers, and other health groups.

"These are days of great change," he stated. "I am pleased to participate in a small way to help shape this change, or, at least, to study the changes as they are proposed or might occur. That's what makes this job so interesting."

Dr. Adler joined the Plans in 1968 as a staff physician. He had previously had a general practice in Mattoon from 1946 to 1948. He spent the next 20 years in the Detroit, Michigan area where he was

in private general practice and later spent a brief period as assistant medical director of the Cadillac Division of General Motors. In 1969, he became assistant medical director and assistant vice-president of the Plans, the position he held prior to this appointment.

Illinois physicians who wish information from Dr. Adler directly may telephone (312) 661-4815 or write to him at the Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601.

### Coordinated Home Care Benefits Revised

A revision in the benefits available under the Coordinated Home Care Program now provides coverage for one visit to a physician's office by a patient discharged from a participating hospital into the Program. Payment will be made on the Usual and Customary fee basis.

The Coordinated Home Care Program is designed to help patients go home from the hospital earlier and to restore them to normal family living and functional activity as soon as possible. Not only is this beneficial to the convalescing patient but also it helps to make more hospital beds available for acutely ill patients.

Devised exclusively for patients under 65 years of age, the Program allows for an early discharge from a participating hospital provided pre-discharge planning for continuity of patient care has been arranged. The patient's own physician decides when a patient may be referred into the Coordinated Home Care Program and this physician remains in charge of the case.

Besides the benefits for the office visit, Blue Shield will pay the physician on the Usual and Customary fee basis for visits which he makes to the patient's home for necessary services while the patient is under the Program.

For further information regarding requirements for eligibility and answers to any questions, see our article in the March 1969 *Blue Shield Report* or contact the Coordinator, Home Care Program, Blue Cross Blue Shield, 222 North Dearborn Street, Chicago, Illinois 60601.



Morton W. Adler, M.D.

(This is not an advertisement)



## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

## FOOT CARE BENEFITS AND EXCLUSIONS

Payment under Medicare Part B may be made for foot care services performed by a physician or licensed podiatrist. However, the scope of benefits is limited by the following:

1. No benefits are available for the care or correction of "flat foot", defined by the Social Security Administration as a condition in which one or more arches in the foot have flattened.

2. No benefits are available for surgical or non-surgical treatments undertaken for the sole purpose of correcting subluxations of the foot *as an isolated entity*, i.e., treatments of partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot.

However, benefits are available for reasonable and necessary diagnosis and treatment, except for the use of orthopedic shoes or other supportive devices for the foot, of symptomatic conditions such as osteoarthritis, bursitis, tendonitis, that result from or are associated with partial displacement of foot structures. Also, surgical correction of a subluxation of a foot structure that is an integral part of a foot injury, or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition, is a covered service.

3. Routine foot care is *not* a covered service. This includes the cutting or removal of warts, corns, calluses; the trimming of nails; and other hygienic and preventive maintenance care in the realm of self care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury, or symptoms involving the foot. Foot care such as routine soaking and application of topical medication on a physician's order between required visits to the physician is not covered.

However, the patient may have certain disease processes which make hazardous to his health the performance of services such as the cutting or removal of corns, warts, calluses or nails by a person other than a professional. If the patient is *under the care of a doctor of medicine or osteopathy* for a metabolic disease such as diabetes mellitus or for other conditions which have resulted in circulatory embarrassment or areas of desensitization in the legs and feet and such a procedure would present a hazard, the procedure would not be considered routine and could be eligible for benefits.

Benefits may also be provided for services ordinarily considered routine if these services are performed as a necessary and integral part of otherwise

covered services (ex., diagnosis and treatment of diabetic ulcers, wounds and infections).

4. No coverage is available for orthopedic shoes and other supportive devices for the feet. An orthopedic shoe which is an *integral part* of a leg brace is covered, but no payment is made specifically for the shoe. Rather, payment is based on the reasonable charge for the entire leg brace of which the shoe is an integral part.

## NEW RULES FOR NURSING HOME VISITS

The Social Security Administration has announced additional regulations regarding Medicare payments when physicians treat patients in a nursing home.

According to the new regulations, Medicare payments can be made for only *one* patient visit to the same patient in a nursing home in a calendar month. Payment for additional visits for a specific patient will be made only when the physician substantiates the medical necessity for more than one visit.

When only one patient is visited, payment will not exceed the maximum allowance for a routine follow-up house call. Also, no additional charge for travel will be paid except in "extraordinary circumstances."

Visits scheduled by the physician to *all* his patients in a home once per month would be allowable. However, when more than one patient is seen in a nursing home, payments will not exceed the customary charge for routine follow-up office visits.

Unless otherwise indicated on the Medicare claim or itemized statement, the Part B Medicare Carrier has to assume that a claim for a visit to a nursing home included more than one patient and will make payment on that basis.

When completing a claim form or itemized statement, the Social Security Administration suggests that you indicate "only patient seen" or "special visit—acute" plus appropriate medical justification for such a visit. This information will help us make payments correctly and promptly.

For additional information contact your Professional Relations Representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601.

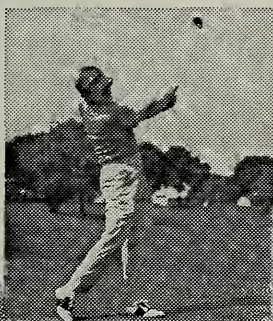
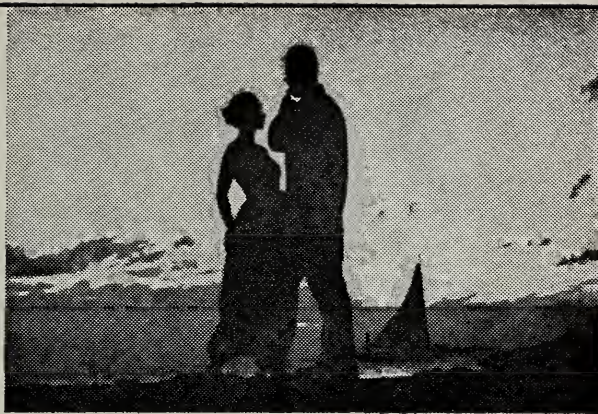
## SSA Certifies New Laboratories

The following laboratories have been certified for Medicare participation by the Social Security Administration:

Downers Grove Medical Laboratory  
4333 Main Street  
Downers Grove, Illinois 60515  
Chicago Portable X-ray Service  
6411 North Troy  
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## the presidents page

# Independent Council on Continuing Medical Education: A progress report

In my Inaugural Address last May I stressed four areas in which I planned to place specific emphasis: peer review, malpractice, continuing education and group practice. In my final report, published in the *Delegates Handbook*, (April, *IMJ*) I reported on progress in these areas. In this, my last President's Page, I will report on recent progress in continuing medical education.

Two years ago Dr. Edward W. Cannady instigated the idea of an Independent Council on Continuing Medical Education and presented it in his Inaugural Address. I have vigorously pushed the idea during this past year. Several meetings have been held with interested parties, representatives of the medical schools, two with a small subcommittee to draw up an organizational plan, and one with the deans of the medical schools. The general idea has been approved by all of these groups, and in March the ISMS Board of Trustees gave its support. A detailed description of the Council was presented to the House of Delegates this month requesting sanction for its formation.

In general, the plan calls for a Congress of about 100 persons to meet perhaps once a year and be composed of representatives of all the medical schools, hospitals, specialty societies and the ISMS. This body would provide outlets for educational programs, innovations in teaching methods, programs, new ideas and advice.

The Board of Directors would consist of representatives from the medical schools and ISMS, with the medical society holding a majority. An

executive administrator and his staff would report to the Board of Directors and would carry out the functions of the organization.

The purpose of the organization would be "to make continuing medical education available to all Illinois physicians."

### Procedures

- a. To motivate physicians to keep abreast of medical advances.
- b. Catalog those who can provide instruction. (schools, specialty societies)
- c. Catalog those outside the profession who have established programs. (commercial organizations, T.V. programs)
- d. Catalog those who are now or who would be willing to present programs. (hospitals, schools, medical societies)
- e. Stimulate the arrangement for programs in different parts of the state.
- f. Serve as liaison between the producers of programs and the sponsors of programs.
- g. Encourage and assist in establishing research in new methods and providing learning experiences for physicians in practice.
- h. Employ computers in listing cataloged items in conjunction with the AMA.

The method of financing the Council has not been completely worked out but to get it started we are asking the House of Delegates to permit half of the AMA-ERF funds for one year to be diverted to this purpose.

(Continued on page 560)

# *Abstracts of Board actions*

Board of Trustees Meeting  
**March 13-14, 1971**  
Ambassador Hotel, Chicago

## **Special Meetings of the House**

A special meeting of the House of Delegates has been called for 10 a.m., Saturday, May 15, to consider the question of Foundations for Medical Care, including their establishment and method of operation throughout the state of Illinois. Discussion and decisions will be limited to the subject of providing medical care through Foundations. The regular session of the 1971 House will open the following day as scheduled. Both the special and regular sessions will be conducted in Parlors 4 and 5 of the Arlington Park Towers, site of the 1971 Annual Meeting, which continues through Wednesday, May 19.

A special educational program is planned to acquaint the membership with medical care foundations before the special session of the House opens. Informative materials will be mailed to all members and the subject will be aired at district meetings in selected areas.

## **Fee-Splitting Legislation**

A legislative proposal to outlaw fee-splitting by physicians (H.B. 61) and the ensuing confusing publicity resulting from conflicting medical testimony resulted in the adoption of the following policy statement:

*"We oppose fee-splitting, we support the code of ethics of the AMA and our own state society and we, therefore, agree with the intent of H.B. 61 and we urge our Legislative Council to amend H.B. 61 so that it empowers the Department of Registration and Education to interpret an action taken by Peer Review or by the Ethical Relations Committee of this Society or its component as a ground for the suspension or revocation of a license to practice medicine in all its branches in the state of Illinois."*

## **Health Facilities and Services Planning Act**

The Board voted unanimously to oppose "with all the strength at our command, a proposed Illinois Health Facilities and Services Planning Act, which would provide for rigid control over hospitals and nursing homes through a small state board and poorly defined Comprehensive Health Planning agencies." The bill, as written, would abridge the patient's freedom of choice and could deny non-conforming physicians access to practice facilities. The Trustees approved an Executive Committee recommendation that:

*"If the bill cannot be successfully opposed, ISMS should seek an amendment to provide for open staff privileges in all hospitals (thus establishing that hospital appointment is a right, not a privilege)."*

## **Continuing Education**

Approval was given to a proposal to establish a statewide system to provide for the continuing medical education needs of Illinois' practicing physicians. The plan will be presented to medical school deans who are to be given equal opportunity for participation. The ISMS House of Delegates will be asked to finance the venture by diverting one half of the \$20 AMA-ERF contribution for one year.



## Board Fails to Endorse DVR Fee Program

The Board expressed appreciation to the Illinois Division of Vocational Rehabilitation for plans to improve payments to physicians but withheld formal endorsement, as requested, because the plan fails to fully meet the usual, customary and reasonable fee criteria established by the House of Delegates.

## Dangers of Institutional Agreements

In an effort to alert physicians to the effect of actions which may tend to limit their ability to continue in the private practice of medicine, the Board of Trustees will ask the House of Delegates to adopt the following resolution:

*"Any proposal or arrangement between institutional management and medical staff will be null and void if such is in conflict with ISMS policy on medical ethics or abridges the property right of the individual M.D. endowed upon him by the Department of Registration and Education of the State of Illinois."*

## Endorse Physician Assistant Training

A pilot program for training physician assistants has been endorsed by the Board of Trustees. Operating in the St. Louis area, this program leads either to a certificate or baccalaureate degree. Students will be Army Special Forces corpsmen, Navy "B" corpsmen, registered nurses and other health professionals with suitable qualifications.

## 1972 Dues Structure

The following dues structure for 1972 will be presented to the House of Delegates.

AMA/ERF	\$10.00
Continuing Education	10.00
Benevolence	5.00
General Fund	80.00
	<hr/>
	\$105.00

## Task Force on Physician Shortage

The Task Force on Physician Shortage and Services to Medically Deprived Areas has established liaison with several inner city groups interested in ghetto health care. These are the Urban Doctors Program, Bio-Medical Careers Council, Medical Opportunities Program, ASPIRA, and the Set-Go Talent Assessment Center Program. The Task Force was instructed to continue meeting with these groups to learn how funds are expended and then present specific recommendations to the House of Delegates.

## Other Board Actions

1. Supported the Illinois Department of Mental Health budget of \$334.6 million.
2. Voted to ask for a status report on psychiatric services at Cook County Hospital.
3. Supported legislation requiring state mental health facilities to meet the same minimum standards of accreditation as private institutions furnishing comparable services.
4. Endorsed a hospital income insurance program to be offered to ISMS members.

*(Continued on page 540)*



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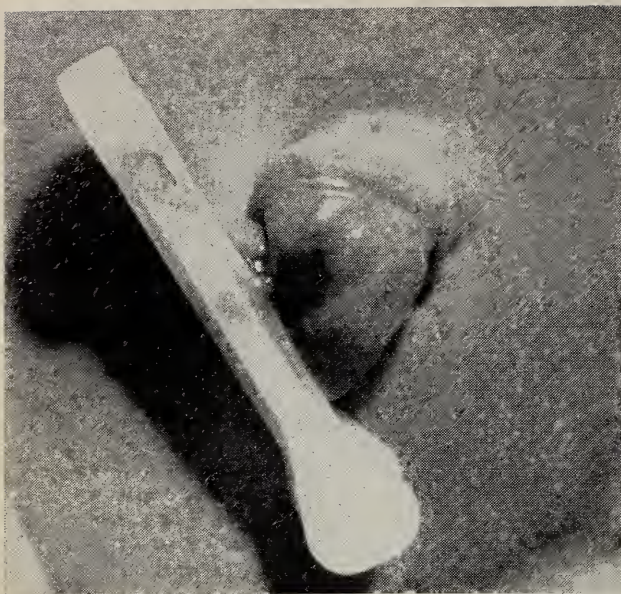
# The patent omphalomesenteric duct

BY CRILE DOSCHER, M.D./MOUNT VERNON

Anomalies of the omphalomesenteric duct are well known and were first described by Yohann Fredrick Meckel in 1801. The Meckel's diverticulum, being the most common of these anomalies, has been estimated to occur from 1.3% in autopsy studies to 3.1% in live clinical material. Patency of the omphalomesenteric duct is far rarer and has a reported incidence of about two out of 30,000 live births for an estimated incidence of 0.0067%. The sex ratio is approximately eight to one, with males predominating. It is not at all clear why these anomalies develop in the fetus during its embryologic evolution. The omphalomesenteric duct is, in actuality, a hollow viscus, connecting the primitive midgut to the almost vestigial yolk sac, during the third to the tenth week of intrauterine life. The omphalomesenteric duct becomes incorporated into the umbilicus about the third to the fifth week as the umbilical area begins to invaginate. Progressive obliteration of the omphalomesenteric duct is the rule, and by the tenth week obliteration is usually complete and separation from the midgut occurs. Spontaneous regression of the now cord-like structure is the rule.

Other developmental anomalies are not uncommonly associated with patency of the omphalomesenteric duct and in general include: omphalocele, hernias, congenital heart disease, mongolism, spina bifida, and cleft lip.





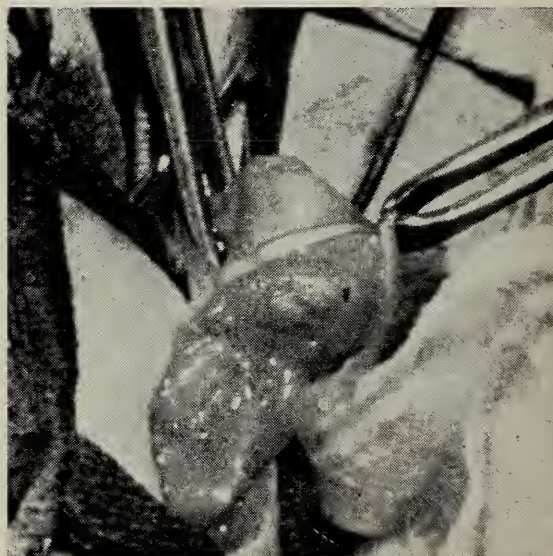
**Fig. 1. External fistulous opening of omphalomesenteric duct.**

### Diagnosis

Diagnosis of this rare lesion is not difficult if one merely thinks of this condition as a congenital fistula, as indeed it really is; an entericcutaneous fistula to be more specific. The estute pediatrician in examining new born infants, will usually encounter this problem first, but occasionally an observing mother, because of her curiosity and concern for her child will call attention to the small red dimple of intestinal mucosa in the umbilicus. This cutaneous manifestation which is the external fistulous opening of this anomaly is depicted in Fig. 1 and 2. It consists of intestinal mucosa and could probably be equated to a miniature ileostomy. A small and intermittent amount of mucous, gas, and/or fecaloid material can be seen issuing from this stoma at intervals. Whether complete or incomplete patency of this tract is present can only be determined by further studies. The dimple should be gently probed prior to surgery. This should be followed by cannulation of the tract and visualization by the instillation of radioopaque material and X-ray interpretation. When the duct is completely patent, the tract usually has its enteric connection in the mid-ileum on the anti-mesenteric border. The cecum and the appendix have been reported, on rare occasions, to be the site of the internal fistula. The usual site of the enteric communication is at the site where the Meckel's diverticulum occurs with frequency. Templeton reported a case of a communicating vitelline duct cyst with its fistulous communication between the umbilicus and the

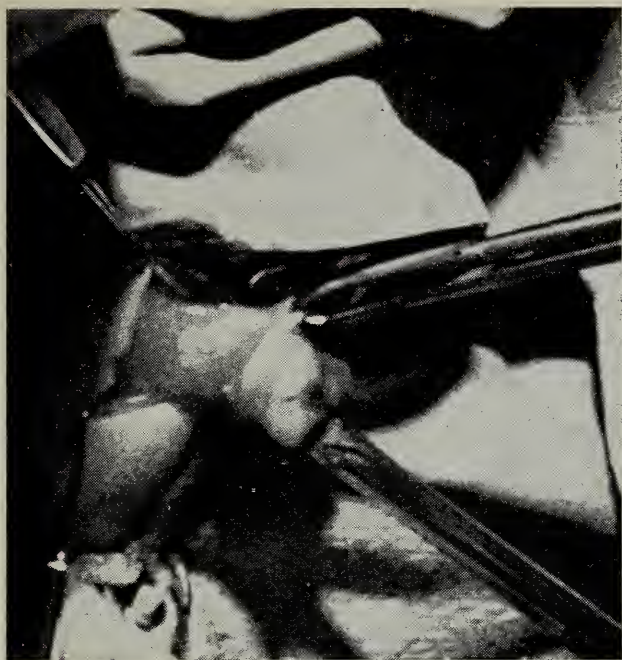
proximal ascending colon. Other congenital anomalies may accompany a patent omphalomesenteric duct and enhance complications. However, the patent duct itself, may indeed produce a life threatening situation to the new born infant if the problem goes undiagnosed or if one of the many complications of this problem occurs. Quarantillo reported a case of a cyst of the omphalomesenteric duct presenting as an acute surgical abdomen. There have been many papers relating the most common complication of the patent omphalomesenteric duct, namely the prolapse of the ileum through the umbilicus. This very serious complication was first described by Peeke in 1811, and it is reported to occur in approximately 20% of published cases of patent omphalomesenteric duct.

Prolapse of the ileum through the persistent omphalomesenteric duct may occur at any time, from birth through teen-age years, though most commonly this occurs within the first month of life. When this most unfortunate complication occurs, immediate surgery is mandatory. Kittle, Jenkins, and Dragstead reported 27 cases of patent omphalomesenteric duct with ileal prolapse. In this significant group, only two survivors remain. There have been a total of 51 reported cases of prolapse through 1964, with only 16 survivors. The other complication, which is hardly as well known, is that of intestinal obstruction at the site of the enteric communication. This occurs because the relatively fixed omphalomesenteric duct causes a windmill effect at the area of terminal ileum where the enteric communication is located.



**Fig. 2. Periumbilical dissection within the confines of the skin.**





**Fig. 3.** Progressive dissection down to the peritoneum.

### Treatment

Once the diagnosis of patent omphalomesenteric duct is made, surgical treatment should be undertaken as a semi-emergency; therefore, once definitive diagnosis is made by gentle probing and instillation of radiopaque material, surgical treatment should be carried out the following morning, unless there are immediate complications, such as ileal prolapse or other problems making this an acute surgical emergency. The infant should be prepared for surgery in the usual manner. No special precautions are taken since these infants are normally excellent surgical risks. It is preferable to carry out the surgery as the first case in the morning if possible, and the child should remain NPO after 4:00 a.m.

Following the induction of anesthesia, a circumferential incision is made around the gelatinous portion of the umbilicus with a small probe in the patent duct. The use of the probe in the duct would seem optional and would depend largely on the personal preference of the surgeon. Gentle dissection is carried down along the umbilicus. Care is taken not to excise the skin in making the initial incision. Removal of this skin edge leaves an undesirable cosmetic appearance, which is unnecessary. The dissection, carried down through the umbilical cord, will insure sufficient remaining skin to fashion an umbilicus at the termination of the procedure. As depicted in Figure 2, dissection is carried down until the two umbilical arteries and um-

bilical vein are identified. These are clamped, divided and ligated. The urachus, which is usually found along the inferior portion of the umbilical cord, is similarly identified and divided. Dissection is then carried down to the peritoneum (Fig. 3). Once the peritoneum is identified, it is incised along the contour of the umbilicus. At this point, the entire umbilicus can be easily delivered through the small incision, bringing along with it the patent omphalomesenteric duct and the loop of ileum where the enteric communication usually occurs (Fig. 4). The enteric communication can now be carefully inspected and identified as to its anatomical location. Once the junction is inspected, a site may be selected for transection of the patent omphalomesenteric duct. At this stage, care should be taken not to tent up the anti-mesenteric border too much so the lumen is foreshortened by the closure of the bowel wall. It is desirable at this point to exercise the fistula and it has been my practice to divide the duct longitudinally along the anti-mesenteric border and to suture the bowel wall transversely, much the same as a Heineke-Mikulicz pyloroplasty is constructed. Figure 5 illustrates the single layer closure of the bowel wall, using the suture material of the surgeon's choice.

The single layer anastomosis has been my practice in pediatric work, since two layer closures, I believe, have no particular advantage and may indeed compromise an already small lumen. Following the construction of the anastomosis, the loop of ileum is replaced within the abdominal cavity and a digital examination of the abdominal viscera is carried out. This, of course, is rather incomplete because of the size of the incision, but a gross examination can be done. Following the termination of the procedure, the abdominal cavity is closed in one's usual manner. In this particular case, the peritoneum is closed with 2-0 chromic catgut and the anterior rectus fascia is closed with 2-0 silk.

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**CRILE DOSCHER, M.D.,** is in the Department of Colon and Rectal Surgery in the Medical Associates Clinic in Mount Vernon. He is a member of the American Proctologic Society. Dr. Doscher received his M.D. from New York Medical College and is a specialist in rectal surgery and peripheral vascular surgery.







**Fig. 4. The enteric communication is carefully inspected.**

The skin, as is usually done in pediatric work, is closed with subcuticular 4-0 chromic and a plastic spray was applied to the umbilical area. The umbilicus appeared as a normal, infant umbilicus producing a desirable cosmetic result by saving all the peri-umbilical skin. These infants may be fed the usual diet for age on the evening of surgery and this is continued until the infant is on a full neo-natal diet. The hospital stay averages approximately three to four days and complications are minimal in the uncomplicated and early recognized case.

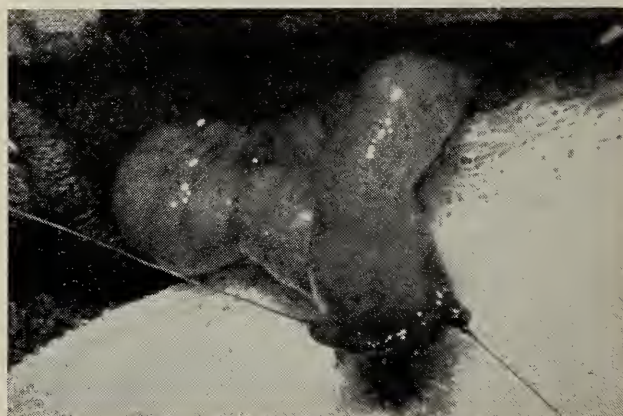
### Summary

A brief description of the history of the patent omphalomesenteric duct and report of a case with the surgical technique described is given. The diagnosis should be made early and surgical treatment should be carried out promptly. The complications of this disease include primarily ileal prolapse which is frequently a lethal type of complication. ◀

### References

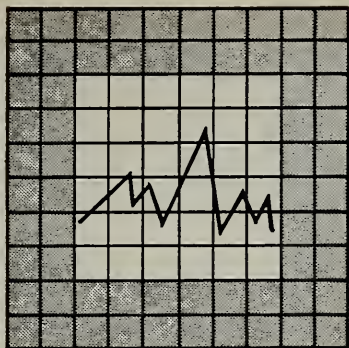
1. Kling, S., "Patent omphalomesenteric duct: A surgical emergency," *Arch. Surg.*, 96:545, 1968.

*(Continued on page 539)*



**Fig. 5. Completion of one layer anastomosis.**





# ekg of the month

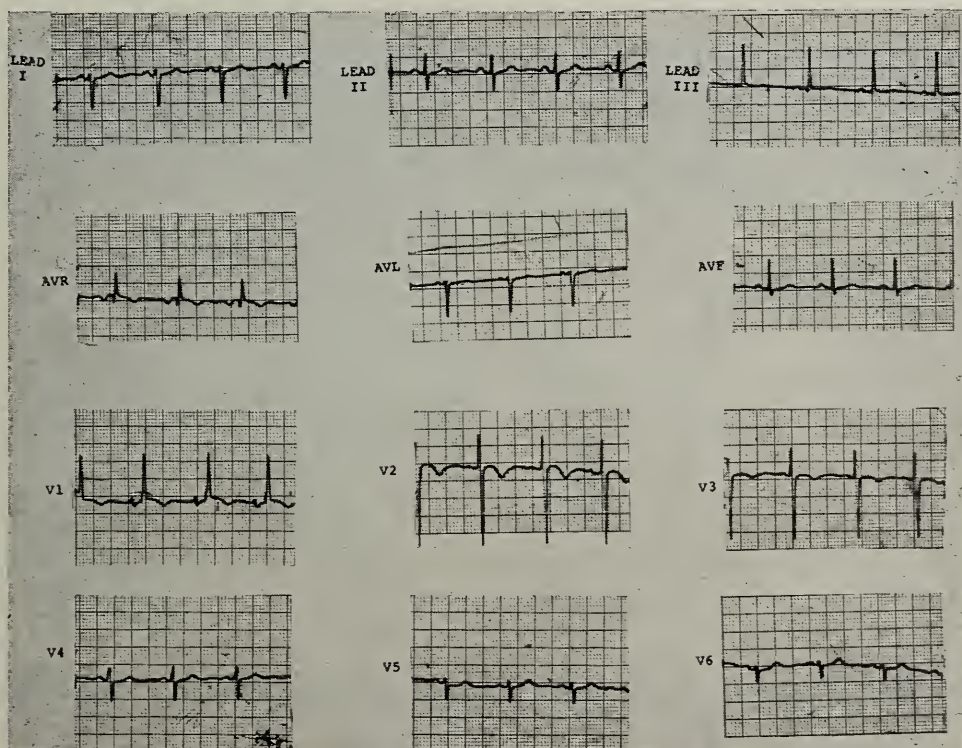
JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS, M.D.  
AND PATRICK SCANLON, M.D./SECTION OF CARDIOLOGY,  
DEPARTMENT OF MEDICINE  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

A 32-year-old, white female was admitted with complaints of progressive dyspnea with exertion, fatigue and orthopnea. Physical examination disclosed malar flush and slight cyanosis. A prominent presystolic pulsation was present in distended neck veins. Palpation of the precordium disclosed a sustained systolic para-sternal lift and a palpable first heart sound at the Left heart border. Auscultation revealed an accentuated first heart sound at the apex. The second heart sound was closely split and accentuated, especially the pulmonic component, at the 3rd Left intercostal space and the sternal border. The second heart sound was followed, at 0.06 sec., by a mitral valve opening sound (opening snap). The OS was followed by a diastolic rumble with presystolic accentuation.

**Questions:** (One or more of the following may be correct.)

1. The electrocardiogram showed:
  - a. Right atrial enlargement
  - b. Right axis deviation
  - c. Left ventricular hypertrophy
  - d. Right ventricular hypertrophy
  - e. Left atrial enlargement
2. The most likely clinical conclusions are:
  - a. Pulmonic stenosis
  - b. Cor pulmonale
  - c. Pulmonary hypertension
  - d. Aortic insufficiency
  - e. Mitral stenosis

(answer on page 558)





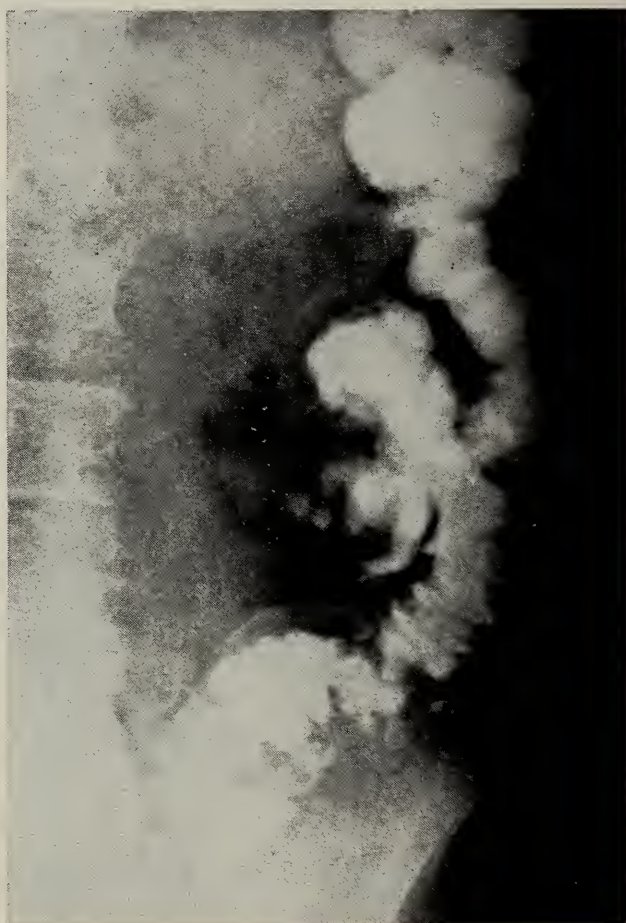


## surgical grand rounds

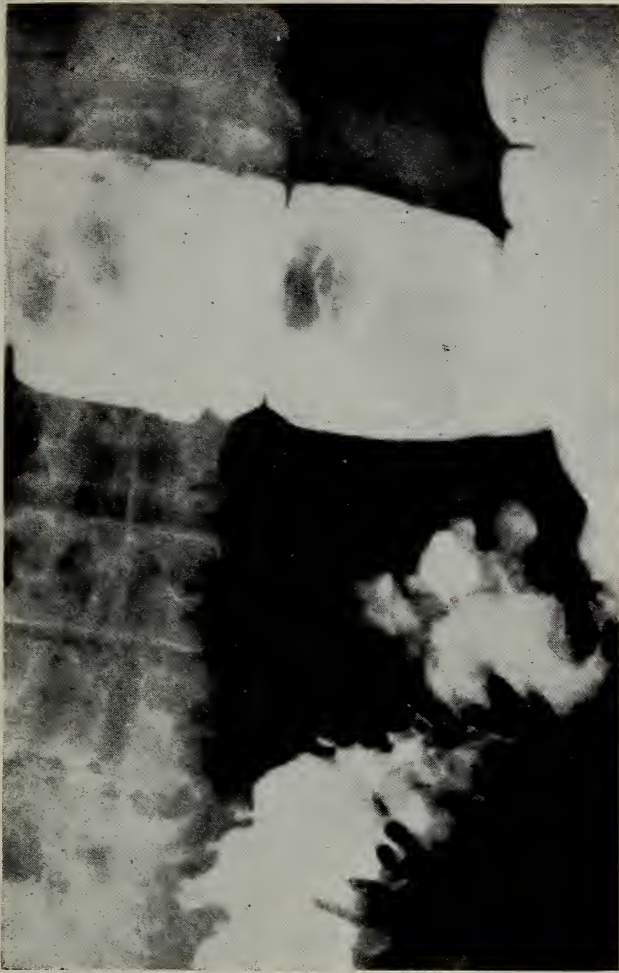
*Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in Offield Auditorium, Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 13, 1970.*

EDITED BY JOHN M. BEAL, M.D./CHICAGO

# Carcinoma in perforated diverticulum of the colon

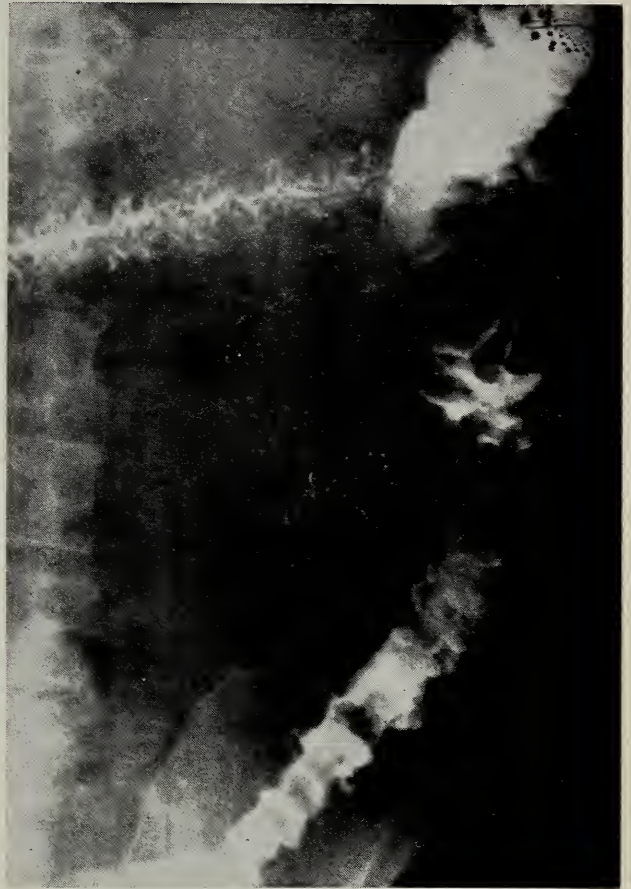


**Fig. 1:** Barium enema performed May 13, 1970 revealed large collection of barium which extends from the lumen of the colon.



**Fig. 3.** Barium enema, December 2, 1964, showed scattered diverticula in the colon.

**Fig. 2.** Barium study of colon February 22, 1968 demonstrated multiple diverticula with large diverticulum just beyond the splenic flexure.



### Case Report:

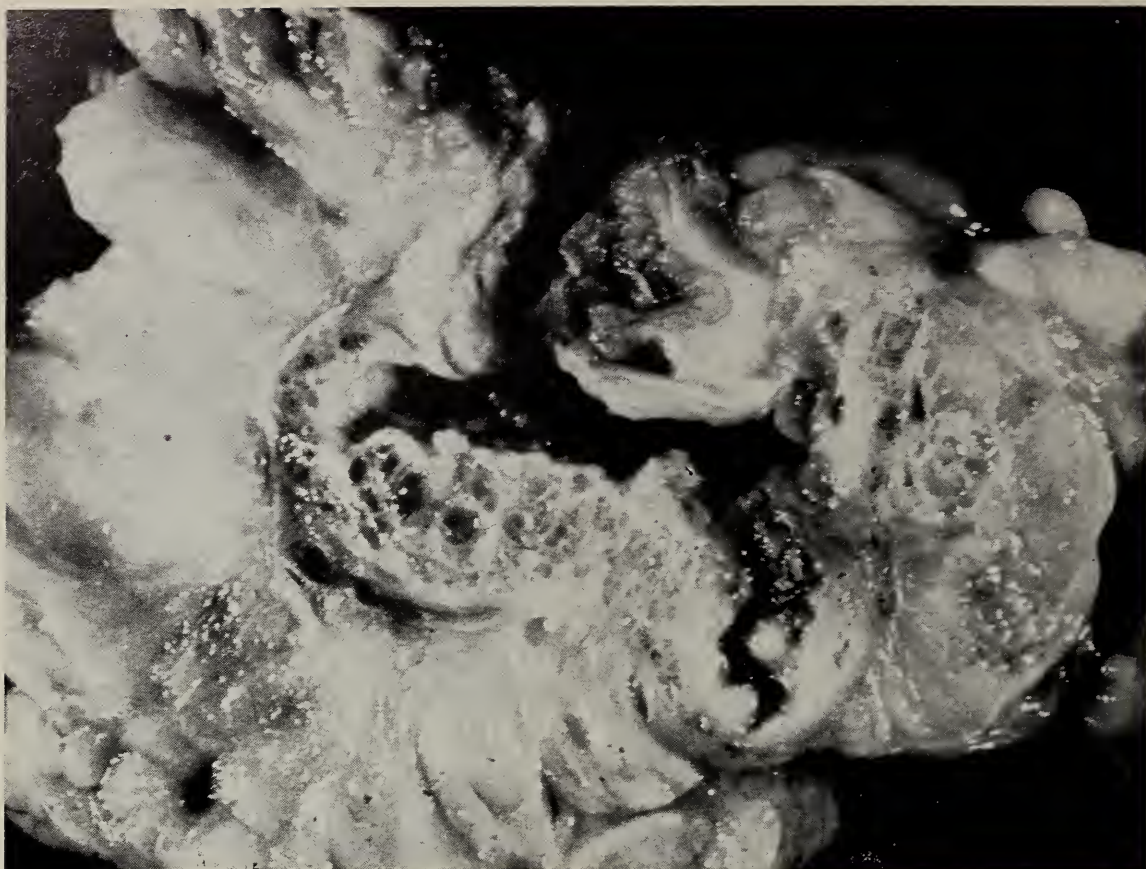
**Dr. Anthony Schaeffer:** This was the third admission of a 65-year-old Negro woman to the Chicago Wesley Memorial Hospital who has been treated for problems relating to diverticular disease of the colon for more than five years. The patient was admitted for the first time in December, 1964 with perforated diverticulitis and treated by conservative means. Since that time, she has experienced at least two episodes of rectal bleeding for which she was admitted to the hospital in February, 1968. The symptoms of the present illness were traced to February, 1970, when the patient began to have increasingly severe left lower quadrant abdominal pain which radiated to the back. She denied weight loss, melena or change of bowel habits during this interval, although she had noticed fluctuation

in abdominal girth. The patient admitted, that at the time of her previous admission, operation had been advised and that she had refused.

Physical examination was unremarkable. Abdominal masses or tenderness were not present. Laboratory data were within normal limits. Roentgenograms were obtained.

**Dr. Abram Cannon:** A colon study done in May reveals multiple diverticula of the descending colon with a large collection of barium that extends out of the confines of the lumen (Fig. 1). On the evacuation films, this area empties very nicely. In 1968, she had a similar lesion, with the barium extending out of the confines of the colon with the multiple diverticula (Fig. 2). She had previous studies in 1961 and 1964 which merely show multiple diverticula along the descending colon (Fig. 3). This looks like a per-





**Fig. 4.** The large diverticulum has been transected and thickened wall is apparent.

forated diverticulum. We thought she had formed an abscess around a perforated diverticulum. It is quite irregular in shape.

**Dr. Juda Jona:** The preoperative diagnosis was diverticular abscess. At the time of operation, there was no evidence that we were dealing with a malignant process. There were the expected findings of diverticular abscess, a hard mass with adhesions of the omentum attached and some migration of fat from the mesentery over the area. The bowel, itself, was mobile and lymph node involvement in the mesentery was not apparent. A left hemicolectomy for a diverticular process was performed. The specimen was opened and inspected in the operating room and the mucosa did not show abnormalities other than an opening that communicated with a cavity. We were greatly surprised when the pathologist notified us that carcinoma was found in the cavity of this abscess.

**Dr. Paul Putong:** The submitted surgical specimen was a segment of colon that measured 36 cm. in length. In the center of the specimen was a firm mass. On cross section, a saccular structure lined by mucosa was present in the center of the mass. The neoplastic nature of the mucosa was

apparent on microscopic study. Heaped up, pseudo-stratified formation of the nuclei was evident. Deep in the subserosa, mucus secreting glands were found that infiltrated practically the full thickness of the colonic wall, characterized by the absence of a muscular layer (Fig. 4).

**Dr. Jona:** The association of carcinoma and diverticulitis was thought to be a true one in the earlier part of the century. The first account of this was made in 1911, and was followed by a report by Dr. Mayo in 1917, who reported an incidence of over 30% of carcinoma in people with diverticulitis. It was proposed that a pattern of chronic irritation and inflammation predisposed the patient to metaplasia and neoplastic changes in mucosa. However, in 1924, Judd and Pollock re-examined Mayo's series and concluded that a patient with diverticulitis really is not more prone to development of carcinoma. The relationship between diverticulitis and carcinoma seems to be casual.

Reports in the literature now indicated that between one and 15% of people with diverticulitis develop carcinoma. The most serious problem for the clinician and the radiologist is often to determine whether a lesion in the colon is di-



verticulitis or carcinoma. Localio, in New York, found that approximately one percent of people under the age of 59 with diverticulitis developed carcinoma. However, after the age of 60, the incidence rose to approximately 25%.

Several comparisons have been made clinically between carcinoma and diverticulitis. The history in patients with carcinoma is usually short in duration, often less than one year. With diverticulitis, there is a history of previous attacks and recurrent episodes. Bleeding with carcinoma is usually occult, while in diverticulitis bleeding is usually absent or rather massive. Patients with carcinoma demonstrate weight loss, usually a nontender mass is present, and obstruction may be present; while patients with diverticulitis have a tender mass, pain, episodes of fever and leukocytosis. Diverticulitis is more frequently associated with urinary tract symptoms than in carcinoma.

From a radiologic standpoint, the segment involved by carcinoma is shorter in length than in diverticulitis, is well circumscribed and has rather abrupt borders with shoulders or margins that give an "apple core" type of deformity at times. The mucosa overlying a neoplastic lesion is disorganized. In diverticulitis, the segment is longer and more rigid when observed on fluoroscopy, the transition of normal to involved bowel is gradual and the mucosa usually appears intact, sometimes with a "saw-tooth" appearance. As in the present case, the history of the deformity of more than two years' duration and absence of other symptoms of carcinoma usually leads to a preoperative diagnosis of diverticulitis.

**Dr. Peter Rosi:** I have seen cases of diverticulitis in which obstruction developed and was then found to be caused by carcinoma. In those instances, the X-ray findings were quite typical of carcinoma. I agree that the development of carcinoma within the diverticulum is unique, although there is no reason that it should not. There is no reason to believe that the mucosa in the diverticulum is either more or less susceptible to the development of carcinoma than the mucosa in the adjacent bowel.

**Dr. James Hines:** There are several aspects upon which I would like to comment. When we opened the specimen in the operating room,

the mucosa was intact and all we could see was a small diverticular opening. The diverticular opening was examined and what appeared to be a thick walled abscess was present so we were surprised to find out two days later that it was carcinoma. An inadvertent hemorrhage in the splenic capsule was caused by traction on the splenocolic ligament at the time of operation, and splenectomy was required. This complication of operation can be avoided usually by a longer incision. If the splenic flexure is carefully dissected, traction on the spleen is not necessary. There is a precedence for chronic inflammatory lesions becoming malignant. We know that people who have 1,000 rads to the thymus develop carcinoma of the thyroid 15 years later. Epidermoid carcinoma can develop in skin with radiation damage or in old burn scars. Chronic ulcerative colitis is an inflammatory disease that can lead to pseudopolyposis and carcinoma. There are other examples, so it is not surprising that this has happened here.

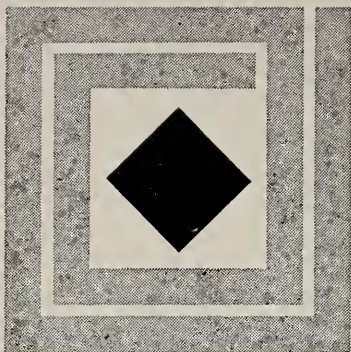
**Dr. John Beal:** Were the lymph nodes involved with metastatic carcinoma in this instance?

*(Continued on page 560)*



**Fig. 5. Microscopic study demonstrated mucus secreting gland, infiltrating the colonic wall.**





# the view box

BY LEON LOVE, M.D., CHAIRMAN/DEPARTMENT OF RADIOLOGY LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

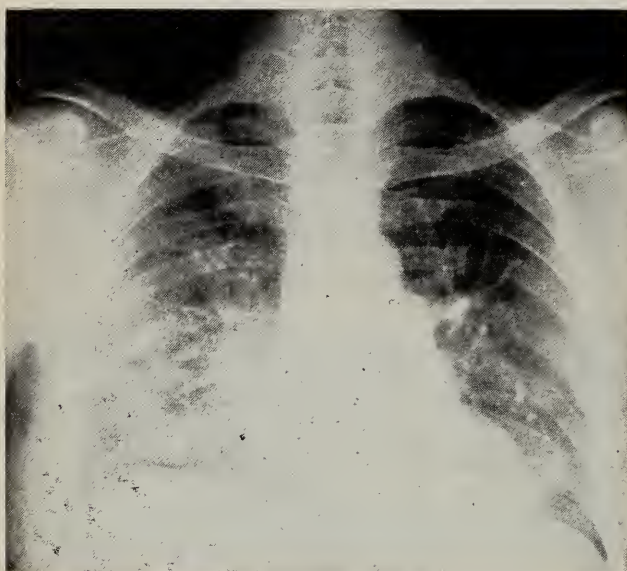


Fig. 1



Fig. 2



Fig. 3

This 40-year-old, white male entered the hospital because of a slightly productive cough and increasing progressive dyspnea. He also complained of pain in the hands. Physical examination revealed occasional rales at the right lung base. What's your diagnosis?

- 1) Lupus erythematosus
- 2) Rheumatoid lung disease
- 3) Scleroderma
- 4) Polyarteritis nodosa

(answer on page 558)

# Management of the patient with terminal illness

BY J. ERNEST BREED, M.D., PRESIDENT, ISMS/CHICAGO

*Read on May 2, 1970 at the "Convocation on Medicine and Theology" presented by the Wisconsin United Methodist Church and the University of Wisconsin Medical Center.*

In considering the management of a patient with terminal illness I think of the story of the old reprobate who had just been informed he was dying. At the doctor's suggestion he agreed to see a minister. The minister knowing of the patient's evil ways asked him if he wouldn't like to forsake the Devil and embrace the Lord. The patient said "I certainly would like to embrace the Lord." The minister added "but you must also forsake the Devil." To which the patient replied "I am in no position to irritate anybody."

It is paradoxical that at the time demographers are announcing the inevitability of death of millions by starvation due to the population explosion, physicians are devising new methods to keep old and unproductive citizens alive. We also compound our problem by keeping alive the defective young until they can pass on their defects to the next generation. In time, they will infect the entire population with genetic aberrations that will require massive effort and expense to provide even the semblance of a normal life for many.

Although little has been said about the pollution of our germ plasm much has been said about the pollution of our environment. Since environmental pollution is a function of the population, in spite of efforts to clean up our air and water, as the population increases the pollution will also increase. At the recent 136th meeting of the American Association for the Advancement of Science in Boston, Barry Commoner of Washington University along with

other scientists professed "they could see no future for man after the year 2,000 due to the increases in numbers of people."

In a few more generations, society may decide to sterilize all defective children shortly before puberty as a partial solution to the problems of overpopulation and inherited defects. This would be done if mental, physical, historical or chromosomal aberrations are apparent on careful examination. The Fallopian tubes of the girls and the vas deferens of the boys could be severed. Thereafter, they could live a normal life except they could not contaminate future generations. Certainly, in the breeding of animals other than man, using inferior stock for reproduction would be considered stupid. Robert H. Finch, former Secretary of Health, Education and Welfare, recently suggested, "the starting point for improving the quality of life would be for parents to limit themselves to two children."

Recently an unidentified English physician, writing in *Medical World News* decried the percentage increase in the numbers of old, weak and unproductive citizens. He sees the growing number of those over 65 as a threat to the human race. He cautions against large scale use of heart transplant surgery, which he says "will be a process of replacing the young with the old."

Cold logic would dictate that the moribund patient should be "put out of his misery" as practiced for an animal in a similar condition. It may have been so in the beginning, but apparently at some time man realized that to be



# **"A doctor should never lie to the**

spared himself he must adopt a philosophy of "live and let live" or "do unto others as you would have others do unto you."

In this country, ever since its inception, the individual has been guaranteed many "freedoms," including freedom to live as he wishes, and freedom to have as many children as he wants. He is guaranteed life as well as liberty. Usually extreme efforts are made to keep him alive when he is seriously ill. When the "science and art" of medicine was of small proportions this did not require great effort, but with our present sophisticated ability to keep the body tissues alive, we have developed serious problems. How long do you continue heroic measures when hope of spontaneous life is gone? To deliberately shorten a life is viewed as "murder" and thereby punishable. The evaluation of a physician in the public eye is in part based upon his dedication to the principles of prolonging life and making his moribund patient comfortable, both physically and mentally.

In our effort to do all we can for the terminal patient, we find at times that we impinge on the "rights" of others by maintaining hopeless and half-dead cripples through what are essentially artificial umbilical cords. When most of our facilities are preempted in caring for them, other citizens are denied the care they seriously need. Recently, a physician observed 20 doctors engaged in a heart transplant operation in his hospital. He reflected on how much more productive it would have been if those doctors had spent this time working in a clinic for the poor.

Perhaps the statements made so far are slightly on the radical side; however, they emphasize significant facts we tend to neglect and have been made primarily to stimulate your thinking. Just for the record, I state that as most other physicians and clergymen, I am dedicated to prolonging a human life as long as feasible.

I am a bit disturbed by the term "terminal illness." If we mean—and we usually do—that the patient will die within a matter of days or weeks, then I would like to know by what authority a doctor or anyone else pronounces this sentence. Doctors are usually wrong if they attempt to foretell the time of death. If by "terminal" we mean a pathologic process that is present and will eventually take one's life, then I dare say that most of us are suffering such a

condition. Perhaps we have a slight thickening of our arterial walls in the kidney, brain or heart that many years from now may increase and cause our deaths.

When it is agreed that the patient's demise is not far removed, the question always arises on what to tell the patient. A doctor should never lie to the patient or his family, but this does not mean he must go into all the details of the anticipated death. Occasionally a young doctor will do this in his desire to develop a reputation of being totally honest. However, there are many hazards to patient, doctor and family by such a course; the doctor may be wrong in his diagnosis or his prognosis. Most often, patients do not question the doctor too closely, giving one the feeling that they really do not want to know, perhaps fearing they may lose what little hope they have.

The patient's reaction on learning of his anticipated death is unpredictable. The reaction of the family is also unpredictable. About two years ago a mother of two teen-age boys became ill and was taken to a hospital. Her physician diagnosed her trouble as leukemia and informed her and her family that she was suffering a "terminal illness." All the high strung members of this little family spent hours weeping, separately and together. Finally one of the boys took a revolver to the hospital and shot his mother in the head. Arrested and tried for murder, he was acquitted on the defense that he loved his mother and did not want her to die a slow and painful death. It was not brought out in the trial that leukemia is seldom painful and that at times chemotherapy or irradiation may bring about a remission that may last for many months. In this case the doctor was incorrect, for leukemia proved not to be her "terminal illness" since she died of a gun shot wound in her head.

I specialize in the treatment of malignant disease and see many very sick patients. It is my habit to advise the family of my opinion of the patient's illness, being as honest and gentle as I can. I never lie to the patient. I do not voluntarily advise him of a bad prognosis. If he asks, I tell the truth, but try to leave a little room for hope. Every patient and every disease state is different. How a particular patient will respond to treatment and how much natural re-

# patient or his family . . ."

sistance he has to the ravages of his disease are qualities no doctor can know in advance. Some hope, even if only for a little more time, can be held for any patient, no matter how sick. Certainly, to kill all hope is fatal for most patients; not only will their lives be shortened but almost every waking moment will be a living hell.

Almost no one who is mentally sound wants to die. Self-preservation is our most compelling instinct. The young, and in general all people who are in good health, may maintain that when they become old and incurably sick they will want to die. When the time comes, however, they change their minds. Among several thousand of my seriously ill patients, a few have expressed the wish to die. Usually the statement is made in self pity or to get sympathy. Occasionally a very old patient, whose relatives and friends have all died and who is in constant discomfort, will say it and really mean it. However, I think of the 96-year-old grandmother of my nurse, who was blind for the last eight years of her life. She spent her days eating and praying to die, but when she would feel ill she would call her family and say "get the doctor, quick."

The use of extraordinary measures of life extension may permit the patient to live a long and useful life, but conversely these measures may condemn the patient to painful and prolonged dying in which patient, family and doctor suffer together in futility. Our ability to prolong life beyond what formerly would have been the end, adds a new dimension to the practice of medicine which may be called "value judgment." How valuable will be the extension of life? What will be the price in terms of suffering, of finances and of sacrifices by the family? Obviously, the physician must fill in the background of life expectancy and usefulness, but decisions as to procedure should be made partly by the doctor, partly by the family, and when possible, by the patient.

We badly need a definition of "death." Perhaps the best definition to date is by Dr. Frank J. Ayd: "'Clinical death' is present when spontaneous respiration has ceased and the heart has stopped beating; and 'biological death' is death of the tissues."

He asks several pertinent questions. "Should the doctor delay biological death after clinical death by keeping tissues alive with stimulants,

respirators and other resuscitative devices? If he does, can he at any time discontinue the artificial means of preserving a semblance of life? When clinical death has occurred, can a physician ask the family's permission to delay biological death long enough for the removal of an organ for transplantation to another whose life may be saved by spare part surgery? If such permission is obtained when does the patient die, before resuscitative measures or after they are discontinued? When a patient with a cardiac pacemaker or an artificial heart is moribund and realistic hope for recovery is gone, is he murdered by the doctor who turns off the current? When is a person dead? Those questions not only concern physicians, but should concern philosophers, theologians, moralists, lawmakers, judges; in fact, everyone."

A few years ago, the medical profession awoke to the realization that in the pursuit of scientific excellence, doctors had lost contact with patients. The time-honored "doctor-patient relationship" had been strained. The patient saw many specialists, none of whom he really got to know. He missed the reassurance and guidance of the family doctor, who, knowing the patient's social and religious background, would often suggest that the patient discuss his fears with his pastor. Realizing this about eight years ago, the American Medical Association established a Department of Religion and Medicine and obtained a minister as director—Dr. Paul McCleave. This department has grown rapidly and proved to be a very great aid in the care of many patients, particularly those who are seriously ill.

The modern scientific doctor may have no concept of the patient's religious needs or the extent of his apprehension. For this reason, the Illinois State Medical Society produced a booklet entitled *What the Doctor Should Know About His Patient's Religious Needs*. Sixteen thousand copies were published and presented to doctors and hospitals throughout Illinois. The American Medical Association, in turn, sent copies to all state societies for their religion and medicine committees.

The need for ministerial assistance is much greater when the patient is without a "family doctor" in whom he has confidence and who has

(Continued on page 549)



# Monitoring of Intrathecal P

## During treatment of P

BY WARREN FUREY, M.D., IVAN CIRIC, M.D., AND RICHARD H. PARKER, M.D./CHICAGO

Meningitis, caused by *Pseudomonas aeruginosa*, is a potentially treatable yet often fatal infectious disease. Successful treatment usually requires intrathecal administration of polymyxin B. Ideally one wants to achieve an effective cerebrospinal fluid concentration of polymyxin B without exposing the patient to any side effects associated with unnecessarily high concentrations of polymyxin B.

A case of pseudomonas meningitis, occurring as a complication of craniotomy, gave us reason to critically review the problems associated with therapy of this infectious process and utilize the determination of cerebrospinal fluid bactericidal activity as a guide to intrathecal dosage.

### Case history:

One month prior to admission, this 44-year-old male became lethargic and had difficulty holding things with his left hand. Urinary incontinence began a week prior to admission.

Physical examination revealed a well-nourished, lethargic male with poor attention span. Bilateral papilledema was present. Except for a left hemiparesis, the remainder of the physical examination was normal.

Admission routine laboratory tests were normal. A radioactive brain scan and a right retrograde brachial angiogram revealed changes consistent with a large, vascular, right frontal lobe lesion.

Two days after admission, the patient was taken to the operating room and right frontal osteoplastic craniotomy was done. An orange-sized, extremely vascular meningioma was exposed. Profuse hemorrhage during the process of resection necessitated terminating the procedure before the entire tumor could be excised. A large amount of gelfoam and surgicel was used to control the bleeding.

Postoperatively the patient was given dexamethasone, 6 mg, every six hours, which was gradually tapered and discontinued on the twenty-sixth postoperative day. On the eleventh postoperative day, the craniotomy flap was noted to bulge. Seven days later a right retrograde brachial angiogram showed the anterior cerebral artery to be midline. Evidence of residual tumor was seen on the right side close to the falx and frontobasal area. Papilledema was still present, but the patient was awake, eating and appeared well.

On the twenty-third postoperative day, the patient's temperature was over 101° (Fig. 1), and there was marked bulging of the frontal flap. A spinal puncture revealed clear cerebrospinal fluid with protein 150 mg/% and glucose 50 mg/%. The following day the bulging wound was drained through a small opening in the very thin postoperative scar.

The dark brown drainage contained pieces of surgicel and gelfoam. Culture of this material proved sterile, but antibiotic therapy was insti-

# Polymyxin B dosage

## pseudomonas meningitis

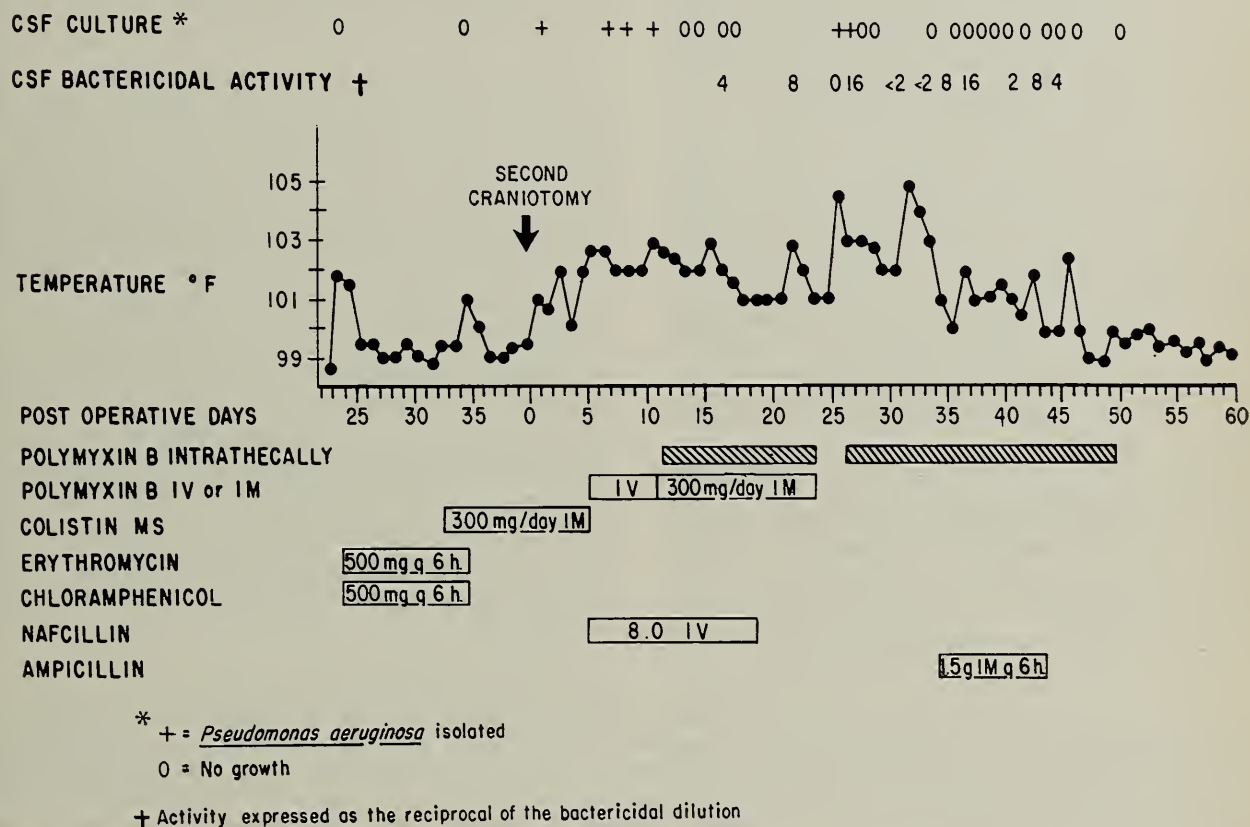


Fig. 1. Hospital course of patient with pseudomonas meningitis showing relationship to second craniotomy and response to intrathecal polymyxin B therapy. Note that CSF cultures remained positive until intrathecal polymyxin B was used and became positive when intrathecal polymyxin B was temporarily stopped 23 days after the operation.

tuted with chloramphenicol and erythromycin. *Pseudomonas aeruginosa* was initially isolated from the wound drainage 26 days after surgery, however cerebrospinal fluid obtained on the thirty-fourth postoperative day was sterile. The patient continued to have low grade temperature peaking at 101°. Colistin methanesulfonate 150 mg intramuscularly every 12 hours was started 32 days after craniotomy. Chloramphenicol and erythromycin were discontinued 35 days after the operation, and the following day the patient became afebrile.

Drainage from the craniotomy site suggested the need for removal of surgical and gelfoam from the wound. Therefore, 39 days after the first surgery, the patient was taken to the operating room and re-explored. The previous tumor bed was filled with necrotic debris, surgical and gelfoam, and in the process of debris removal, the remaining tumor was encountered in the depth of the anterior cranial fossa overlying the cribriform plate. Surprisingly, the tumor began delivering itself spontaneously until it lay on the surface where it was easily removed. After hemo-



stasis was achieved, the dura mater was left partially open and the bone flap removed because of possible infection. A drain was placed in the tumor bed. Upon its removal 36 hours later, a cerebrospinal fluid fistula remained. With closure of the fistula, there was a rapid bulging of the wound and a decrease in the level of consciousness. As soon as drainage was re-established, the patient's condition improved. Swabs of the operative site revealed *Pseudomonas aeruginosa*. Cerebrospinal fluid drainage obtained two, seven, and eight days after the second operation grew *Pseudomonas aeruginosa* and coagulase positive *Staphylococcus aureus*. Colistin methanesulfanate was stopped five days postoperatively, and polymyxin B sulfate, 300 mg per day (3 mg/kg) was started intravenously. Two days later, intravenous nafcillin, 8 to 12 grams per day was added to the regimen.

The patient became lethargic on the eighth postoperative day. The neck was supple and vital signs remained stable. The wound healed well except for one corner which still drained cerebrospinal fluid.

On the tenth postoperative day, nuchal rigidity was present. Cerebrospinal fluid (CSF) obtained by lumbar puncture contained 758 cells/mm<sup>3</sup> with 87% polymorphonuclear leukocytes and 13% mononuclear. The CSF glucose was 35 mg/%, with a blood glucose of 140 mg/%. Only *Pseudomonas aeruginosa* was isolated from this spinal fluid specimen. Intrathecal polymyxin B, 5 mg per day, was administered from the eleventh to the twenty-fourth postoperative day (Fig. 1). A total of 55 mg was given during

this period. A spinal fluid sample taken on the 15th postoperative day, immediately before the intrathecal dose of polymyxin B and 24 hours after the previous day's 5 mg dose, was bacteriostatic in a 1:8 dilution,\* and bactericidal at a 1:4 dilution. The CSF glucose was 52 mg/% and blood glucose 100 mg/% on that day. Spinal fluid obtained 22 days after reexploration was bactericidal in 1:8 dilution, and by the twenty-fourth postoperative day, the patient was alert with much less nuchal rigidity. Spinal fluid cultures were negative on the thirteenth, fourteenth, sixteenth and seventeenth postoperative days and though the temperature was still 102°, all therapy was stopped 24 days after the second operation.

Within two days after stopping therapy, the temperature spiked to 105°. Turbid cerebrospinal fluid containing *Pseudomonas aeruginosa* was removed. Intrathecal polymyxin B was started without any parenteral therapy. Within 24 hours after a 10 mg dose, the spinal fluid culture was sterile and the fluid was bactericidal in a 1:16 dilution. Intrathecal therapy was continued, using 5-10 mg doses every day.

During the daily spinal punctures the cerebrospinal fluid pressure was approximately 300 mm. The temperature rose to 103° on the 32nd and 35th postoperative day, at which time the intrathecal dose was kept at 10 mg per day for six days. The patient's appetite improved, the temperature returned to normal, the craniotomy wound healed and cerebrospinal fluid became normal.

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\*Cerebrospinal fluid bactericidal activity was determined as described previously.<sup>15</sup> The *Pseudomonas*(sp.), isolated from the patient, was used as the test micro-organism with an inoculum of 10<sup>4</sup>-10<sup>5</sup> bacteria per tube. Bactericidal and bacteriostatic effect was differentiated by subculture of broth from all tubes showing no evidence of growth after overnight incubation. Antibiotic free media was used from the subculture. No growth following subculture indicated a bactericidal effect.





Fifty days after reexploration, and after 205 mg of intrathecal polymyxin B, therapy was stopped. The patient remained well. When seen two years later, the patient was working regularly although he still had minimal left hemiparesis.

### Discussion

Stanley, in 1947,<sup>1</sup> classified pseudomonas meningitis into two groups based on how the bacilli gain access to the cerebrospinal fluid; either hematogenously or by direct inoculation. In Stanley's series of 69 cases, almost two-thirds were the result of direct inoculation or extension and had a mortality rate of 55%. One-third of the cases were secondary to pseudomonas bacteremia and a mortality of 86% was observed.

Harris, in 1946, reported four cases of pseudomonas meningitis following intrathecal penicillin therapy.<sup>2</sup> Two of these four patients survived following therapy consisting of drainage, sulfadiazine and additional intrathecal injections of penicillin. In 1948, Weinstein and Perin<sup>3</sup> collated reports of 82 cases of pseudomonas meningitis, and added three cases of their own. Weinstein's three cases, all secondary to spinal anesthesia and in prior good health, were cured following treatment with large doses of intramuscular and intrathecal streptomycin, but hearing loss resulted in all three patients. At that time Weinstein concluded that "streptomycin is the *sine qua non* of successful therapy of primary meningitis due to *Pseudomonas pyocyanea*."

In 1958, Weinstein<sup>4</sup> reviewed 26 cases of pseudomonas meningitis treated with intrathecal and intramuscular injections of streptomycin and noted there were 15 survivals. Several of these infections were either of unknown origin or secondary to pseudomonas bacteremia, and the 58% survival rate suggested that streptomycin represented a slight improvement over previous therapies. The potential efficacy of streptomycin is seen in the fact that pseudomonads may be susceptible *in vitro* to 8 to 50 mcg per ml of streptomycin,<sup>3</sup> a level obtainable if daily intrathecal injections of at least 10-20 mg of the drug are used.<sup>7-9</sup> However, many *Pseudomonas* species currently isolated are more resistant to streptomycin and susceptible only to concentrations of streptomycin greater than 100  $\mu$ g/ml.<sup>4</sup> Even with daily intrathecal doses of 50-100 mg it is unlikely that effective antipseudomonal concentrations would be maintained even if achieved at any time. Therefore, serious contraindications to relying on streptomycin now lie in the pseu-

domonas marked variation in susceptibility to the drug as well as their propensity to develop resistance while undergoing treatment.<sup>5</sup> Also, eighth cranial nerve toxicity of streptomycin may be enhanced by intrathecal administration.<sup>7</sup>

Polymyxin B is known to be bactericidal for most *Pseudomonas* isolate. However, it is difficult to evaluate its effectiveness in treating pseudomonas meningitis. In 1950, Hayes and Yow<sup>8</sup> reported the case of a 17-year-old girl cured of pseudomonas meningitis which followed spinal anesthesia using combined intramuscular and intrathecal polymyxin B. The patient suffered two relapses of her disease, and received a total of 78 mg of polymyxin B intrathecally in three treatment periods. Tomlin, in 1951,<sup>9</sup> reported a case of pseudomonas bacteremia and meningitis secondary to a urologic procedure, which was cured with combined intrathecal and parenteral polymyxin B after two months of unsuccessful sulfadiazine therapy. The intrathecal medication was stopped after three days because of pain in the patient's legs and circumoral and perianal anesthesia. In 1952, Jawetz<sup>10</sup> stressed the importance of giving polymyxin B by the intrathecal route and stated that in the absence of systemic infection parenteral therapy was not needed.

Biehl and Hamburger, in 1954,<sup>11</sup> concluded that only polymyxin B showed promise in treatment of pseudomonas meningitis. One of Hamburger's two patients required 58 mg of intrathecal polymyxin B in a 25 day period to effect a cure. In the same year, Trapwell<sup>12</sup> reported the cure of a pseudomonas meningitis in a five and one-half year old child, which developed after surgery and X-ray therapy for a spinal cord tumor. His patient suffered a recrudescence of disease after initial intrathecal and intramuscular polymyxin B therapy, and only after receiving a total of 142 mg of intrathecal polymyxin B was a cure observed. The second course of treatment was continued two weeks after the cerebrospinal fluid was known to be sterile.

In 1958, Nunn and Wellman<sup>13</sup> reported a cure of pseudomonas sepsis and meningitis following open heart surgery, using combined intrathecal and intramuscular polymyxin B therapy, after parenteral penicillin, tetracycline, streptomycin and intramuscular polymyxin B had failed.

The 55% survival of primary infections with drainage and no appropriate antibiotics, as was seen originally by Stanley, the lack of any controlled study of various treatment regimens, and the failure of review articles to distinguish in-



fections as primary or secondary make claims for therapeutic effectiveness difficult to evaluate. Logically, the drug most effective *in vitro* against the offending microorganism should be the one more effective *in vivo*, provided it can be administered by a route which permits it to reach the site of infection. Polymyxin B, a polypeptide antibiotic with poor diffusing properties, is not transported well across membranes. Therefore, intrathecal injection is mandatory for treating meningitis. Gentamicin, another antibiotic with poor transportation across tissue barriers, also has been reported as effective in the treatment of intracerebral pseudomonas infection when given intrathecally in a dose of 100 to 1,000 mcg daily and combined with parenteral therapy.<sup>14</sup> Carbenicillin has been effective in certain pseudomonal infections, but there is still insufficient data to rely upon its effectiveness in life threatening pseudomonas infections. The polymyxins continue to be the most reliable antipseudomonal agents, and while they carry the label of being toxic drugs, it is important to note that our patient received 205 mg of intrathecal polymyxin B without complications.

Measurement of the antibacterial activity of CSF during therapy is an easy and effective means of monitoring intrathecal dosage. In the present case, this *in vitro* test provided a means of titrating the dose of intrathecal polymyxin B so that toxicity from the drug was avoided without compromising the therapy.

### Summary

*Pseudomonas* meningitis following craniotomy was successfully treated with intrathecal polymyxin B. The total dose of 205 mg of polymyxin B required 36 intrathecal injections. No adverse reactions associated with the intrathecal therapy were noted in spite of the duration and total dose of polymyxin B used. Determination of the antibacterial activity of the cerebrospinal fluid (CSF) by a dilution technique made it possible to regulate intrathecal dosage. A bactericidal effect of the CSF against the pseudomonad, causing the infection, was maintained between 1:8 and 1:16 by giving daily intrathecal doses of 5 or 10 mg of polymyxin B.

The results of this case support previous recommendations that pseudomonas meningitis without bacteremia may be treated with intrathecal therapy alone. ◀

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# Gardner's Syndrome

## A variant of congenital familial polyps

BY MOHAMMAD YOUSUF ALEEM, M.D./EVERGREEN PARK

### Gardner's Syndrome as a Clinical Disease

Gardner's Syndrome, as described by multiple authors, is a variant of congenital familial polyps. In addition to polyps or malignancy of the colon, other associated findings include hard or soft tumors of the skin, which are linked with the development of multiple polyposis of the colon. This condition has been described in multiple families in multiple generations. Mode of inheritance observed is autosomal dominant.

Some authors have brought forth the hypothesis of proliferation of mesenchymal connective tissue, associated with the familial tumors. This explains the presence of desmoid tumors associated with familial polyposis.

### Pathology

Sebaceous cysts have long been known to be associated with intestinal cancer. In 1953, Gardner and Richards described the clinical variant of familial polyposis named Gardner's Syndrome. Subsequent studies have strongly supported the hypothesis. Lack of more exactitude is blamed on the understandable failure of past physicians to record in the patient with familial polyposis such apparently unrelated defects as cysts or lipomas of the skin. Different kinds of tumors are usually present in the patient with the syndrome, but varying combinations have been recorded. Osteoma is the commonest of all skin lesions.

### Clinical Features

External manifestations of the syndrome usually precede the development of at least the recognition of intestinal polyposis by 10-20 years.

Multiple sebaceous cysts which are nothing but wens usually appear at puberty. In contrast to the common distribution of such lesions on the scalp and back, these cysts are more common on the face and limbs.

Lipomas and desmoid tumors appear later, especially on the incisional areas, but also appear without inciting cause on chest, scalp and arms. A curious tendency to fibrous hyperplasia promotes development of extensive and dense adhesions after the abdominal operations. This may take the shape of peritoneal fibrous tumors which may be confused with malignant tumors. Those with dense adhesions may lead to intestinal obstruction.

Retroperitoneal fibrous tissue has also been reported without preceding operations. Odontomas and discreet bone tumors of the facial bones, especially maxilla mandible, sphenoid, are part of the syndrome and lend to the cosmetic problem. The adenomas are limited to colon, and like those of the familial polyposis, become malignant tumors 10-15 years after they first become manifest. Otherwise, symptoms are those of any tumor or polyp in the colon; bleed-

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ing, diarrhea and abdominal cramps. Polyps are extremely rare in the small intestine, and pigmentation characteristic of Peutz-Jaghers Syndrome is completely absent.

### Diagnosis

Radiologically, the appearance of the large intestine is like familial polyposis. The membranous bones like maxilla and mandible show localized bony densities which usually project above the skin surface and occasionally remain as foci of internal density, so called endosteal osteomas. The long bones are thickened by irregular cortices, sometimes with frank osteomas.

### Treatment

Colonic adenomas are similarly treated like familial polyposis without the skin lesions. The whole family should be examined. The presence of any of the skin lesions described above should lead the physician to the search of intestinal polyps.

In 1950, Gardner and Stephen presented a pedigree with high incidence of carcinoma of the lower gastrointestinal tract. The pedigree consisted of 68 descendants of one couple. Nine deaths, out of a total of 12 adult deaths were attributed to Gardner's Syndrome. The living members of this family have been followed in a special clinic at Salt Lake General Hospital, Salt Lake City, Utah.

In a follow-up of this pedigree, the following were noted: six members died in infancy or childhood; in a total of 12 adult deaths, seven died of carcinoma of the digestive tract, and intestinal polyposis was the pre-disposing cause of cancer in all of these patients.

In order to determine whether a hereditary pattern was continued in the younger members of the family, examinations, which included sigmoidoscopy and barium enemas, were given to all the living members of this family for detection of polyposis and carcinoma. From a total of 50 living individuals, 34 were negative and five were positive for colonic polyps. Two of the five had well-documented carcinoma of the colon. Nine individuals under six years of age were not examined, and two adults were not examined.

Surface tumors of a known nature and significance were present in all of the members of this family who were alive and had polyposis or carcinoma. Skin lesions were also present in individuals who died of cancer of the colon and rectum. The pattern of simple dominant inheri-

tance of the disease was indicated for both polyposis and skin tumors.

In 1952, in another article by Gardner and Pleuk, simultaneous occurrence of colonic polyps and bone tumors, like osteomas, was described. All six members of the same family with polyposis had evidence of bone tumors. A dominant mode of inheritance was suggested for both of these conditions.

Oldfield (Leeds) in 1954, reported a pedigree of the Taylor family, and concluded that the presence of sebaceous cysts was an inherited dominant characteristic. It was also postulated that familial polyposis might be inherited in a similar fashion. Two members of this family had died of cancer of the colon, while the others were treated with total colectomy and ileostomy.

O'Brien and Wells, from Buffalo, in 1955, reported the presence of desmoid tumors of the anterior abdominal wall in six patients with familial polyposis of the colon. In all of these cases, heredity was stressed as the important factor in the transmission of this disease.

In 1959, William Smith, from Mayo Clinic, reported the occurrence of desmoid tumors in familial polyposis, most of these tumors occurring in the abdominal incision scar of these polyposis patients who had survived an appreciable time after the operation. Some arose *de novo* in extra abdominal sites.

The Mayo Clinic review extended over a period of 23 years (1933-1955), and included 201 patients with multiple polyposis. One hundred and fifty of those patients who had survived the operation were available for follow-up. Eight of the patients had skin lesions, with six of them excised; a diagnosis of desmoid tumor was made pathologically in all of them. Most of these tumors showed areas of localized muscular invasion. An average incidence of 3.5 was figured. The author of this article proposed the following hypothesis for etiology:

"An unusually high incidence of fibromas, desmoid tumors, fibro-sarcomas, osteomas, Leiomyomas and postoperative adhesions in relation with multiple polyposis may be most rationally explained as a result of tendency in polyposis patients to proliferate excessively, cells of mesenchymal origin. Although desmoid tumors are rare, people who have them should undergo a periodic check-up of their bowel for presence of polyps or malignancy."

Gorlin and A. Chandhry, in 1960, reviewed the past literature on Gardners Syndrome and described each of the components of the syn-

drome briefly with reference to respective authors.

Type of Lesion

- 1. Intestinal polyposis  
Authors: Fitzgerald, Gardner, Gumpell and Carballo, Duke, Lochart and Shummary, Collins
- 2. Fibromatous growths  
Authors: Miller and Sweet, Pugh and Nesselrod, Smith, O'Brien and Wells, Weiner and Cooper, Gumper and Carballo, Collins
- 3. Cysts  
Authors: Paget (Hereditary Aspects of Sebaceous Cysts—1858), Siemeus and Munro, Noojan and Reynolds, Anderson
- 4. Leiomyomas  
Authors: Clark, Parker, Gumpel and Carballo
- 5. Odontomas  
Authors: Fitzgerald, Weiner and Cooper
- 6. Osseous tumors  
Authors: Grumpell and Carballo, Gardner and Pleuk
- 7. Lipomas  
Authors: Smith, Fitzgerald

Fate of Patients With Multiple Polyposis of Colon in Gardner's Syndrome

Author	With proven cancer			Surviving without cancer		
	No. of cases	operated	dead Av. age	No. of cases	Treated	Ave. age colectomy
Gardner & Richards (1953)	11	3	11 (41 yrs)	4	0	29 yrs.
Oldfield (1954)	2	2	2 (31 yrs)	1	1	27 yrs.
Weiner & Cooper (1955)	3	3	3 (31 yrs)	1	1	31 yrs.
Smith (1958)	0			17	10	41 yrs.
Hughes & Houston (1960)	2	2	2 (29 yrs)	0	0	0 yrs.
Gorlin & Chaudhry (1960)	2	2	0	3	3	32 yrs.

(Tabulated by Dawborn, Ferguson and Stanistreet, of Insittute of Medical Research and Commonwealth Laboratories, Melbourne, Australia)

In 1962, Victor McKusick, Johns Hopkins Hospital, classified the heredity polyposis of the gastrointestinal tract into six groups.

- Group I Familial Polyposis of Colon
- Group II Occasional Polyps of Colon
- Group III Peutz-Jeghers Syndrome
- Group IV Turcot-Syndrome
- Colonic Polyposis with Brain Tumors
- Group V Gardner's Syndrome
- Group VI Multiple Endocrine Adenomata (Including Zollinger, Allison Syndrome)

Conclusion

Gardner's Syndrome has been described by multiple authors with a definite dominant mode of inheritance. The disease has not been diagnosed widely for the fact that the findings of skin lesions have very frequently not been correlated with the disease in the gastrointestinal tract. It is hoped that this will serve as a reference for the practicing physician for picking out these cases more frequently than has been possible in the past.

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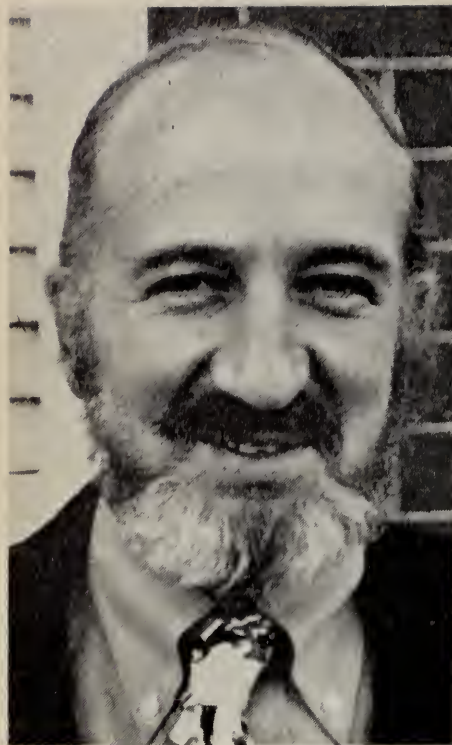
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(Continued on page 539)





"In our new group program, we help the alcoholic deal with his resentments, guilt and fears about the future."

# Alcoholic

## The

BY RICHARD S. COOK/CHICAGO

AS TOLD TO  
MARIAN THIELE/STAFF ASSISTANT  
ISMS DIVISION OF PUBLIC RELATIONS

The scene is a meeting room—a group of people seated around an oblong table covered with a sheet of white paper.

"Close your eyes and picture the wall that separates you from everyone else in this room," says the group leader. A silent pause. "Now open your eyes and draw that wall on the paper in front of you."

Three in the group immediately pick out colored chalk from boxes on the table and begin drawing abstract designs. Another hesitantly reaches for chalk and draws a barbed wire fence. Finally, everyone in the group is filling the table space before them with red, blue and yellow lines.

### "You-and-Me" Feeling

This is the beginning of a typical group therapy session at Martha Washington Hospital's Extended Treatment Program (ETP) for alcoholics. The new and unique program stresses a

"you-and-me" relationship between staff and patients. In the scene just described, some in the group are staff members, the others are patients—and all are on a first-name basis.

Martha Washington Hospital is a 108-bed general hospital at Irving Park Road and Western Avenue on Chicago's northwest side. For over 100 years, Martha Washington has offered detoxification service, which at this time consists of a 29-bed acute medical unit under the skilled and experienced leadership of Dr. Samuel Nieder.

A long-recognized need has been met by the new Extended Treatment Program, which now enables us to deal with the acutely-intoxicated patient

and the patient who wants and needs treatment for his alcoholism.

### Gestalt Therapy

Our accent in ETP is on group therapy, utilizing my recent training in Gestalt Therapy and in conjoint family therapy. Our group experiences have shown me how the "power-for-change" that exists in a group can be tapped for individual patient benefit.

The goals of this group program are to enable the alcoholic person to discover new aspects of himself and to use these discoveries to change beneficially. We also try to help him find new reserves of energy to back up his determination

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**RICHARD S. COOK, M.D.** is Chief Psychiatrist at the Martha Washington Hospital Alcoholic Treatment Center in Chicago. He received his M.D. from the University of Chicago School of Medicine and served his residency in psychiatry at Billings Hospital, Chicago. He is a member of the American Psychiatric Association.

# Treatment: Group Experience

Chicago's Martha Washington Hospital offers a "detoxification service" and meets a long-recognized need with its new Extended Treatment Program

and resolution to manage his drinking.

We want the alcoholic to deal with his over-dependence, resentments and fears about the future . . . anxieties in general,

guilt and other "unfinished business" from the past. He does this by living through experiences instead of merely telling about them.

Staff titles and degrees are

de-emphasized to reduce the significance of the staff-patient roles and to promote person-to-person interaction. This is accomplished even though staff members perform functions for

Martha Washington Hospital, on Chicago's northwest side, has been treating alcoholics for over 100 years.





# detoxification, rehabilitation and follow-up care

the alcoholic people that differ from the obligations the patients perform toward the staff.

We do everything possible to reinforce the patient's desire to get well. This means maximizing his every strength to face and overcome his resistance or his inertia-to-change. Our group meetings are designed to disclose this resistance—to both the patient and the therapist. Once a resistance has been exposed to their attention, they can then combine their efforts to surmount it.

We structure our meetings to prompt the patient to be actively engaged in pressing for the discoveries and unblocking that promote beneficial change. If the therapist merely lectured to the group, the alcoholic could avoid face-to-face dealing with his inertia-to-change by not listening or secretly—and unintentionally—brushing aside what he heard. Or, if the patient were requested to volunteer in every group meeting, he might, without intending to, postpone indefinitely the day when he volunteered to bring up things relevant to himself.

Thus far—in a little less than 14 months—the success rate of the Extended Treatment Program has been heartening. Our Social Service Director, B. S. Parihar, M.S.W., M.A.S., reports that only 16 out of 98 patients who participated in the program from January 15, 1970, through January 30, 1971, have relapsed and returned to our detoxification unit. This means that 84% have not returned to the hospital.

Actually, this figure does not tell the whole story about our treatment philosophy and program. Spontaneous reports from discharged patients have proven our belief that there are delayed as well as immediate benefits from our program. These delayed benefits include participation in our outpatient service after a person inaugurates change in the hospital.

Our new program can be used in a number of ways. Since we accept acutely-intoxicated patients, we can provide a full range of treatment: 1) detoxification; 2) rehabilitation on our Extended Treatment Program; and 3) follow-up care in our outpatient service.

Any physician can refer an alcoholic patient to us. We accept patients for participation in one, two or all three of our treatment areas. If an alcoholic person has been hospitalized in another general or psychiatric hospital for detoxification—and that institution does not have a rehabilitation and treatment program for alcoholism—we can accept his transfer to Martha Washington Hospital's Extended Treatment Program. Although we do not accept involuntary emergency admissions, alcoholic persons who have been committed to other institutions can be transferred to our Extended Treatment Program.

If the referring doctor wishes to continue to follow his patient later, we will refer the patient back after his discharge.

## MDs Role

Follow-up care by the family physician after an emergency commitment is vital for an alcoholic's permanent recovery. Too often, physicians mistakenly believe that the hospital staff or A.A. will provide care after hospitalization on an emergen-



The patient often resists face-to-face confrontation with anxieties and other "unfinished business" from the past.



equal a full range of treatment . . . . .

Staff titles and degrees are de-emphasized to allow for person-to-person interaction during group sessions.



cy basis. The alcoholic benefits from the continued interest and support from his own doctor.

The patient's personal physician can effectively influence his alcoholic patient to want treatment by his relationship of trust and by having some correct knowledge about—and attitudes toward—drinking problems. This means making an enthusiastic effort to present plans for follow-up treatment. The staff of Martha Washington Hospital's Alcoholism Treatment Center is available to help you plan for your patient.

Referring a patient to our Alcoholic Treatment Center requires only a telephone call to the Center's Admitting Office. If you desire additional help, consultation or information, your call will be transferred to our Social Service Department for more detailed consideration. Dr. Nieder and myself are also available for consultation.

If your patient is intoxicated at the time of admission, he will be sent to our acute medical unit. He will be given prompt service, including anti-convulsives, vitamins, hypnotics and fluids routinely.

He will be closely observed for any complication to his recovery. If there are no complications, he will be restored to a reasonable state of physical well-being in about five or six days. I have learned from Dr. Nieder's use of the SMA-12+ profile and liver scanning that there are lingering consequences to excessive drinking in many of our patients.

Following his stay on our medical unit, the patient may either leave or elect to enter the Extended Treatment Program. If he elects to leave, we encourage him to attend to some follow-up care. Our outpatient treatment service is available for effective group therapy. The patient may also

receive Antabuse, Vitamin B<sub>12</sub> shots and other indicated medication. We remind him that A.A. is available—either at Martha Washington Hospital or in his community.

#### ETP Described

ETP staff members visit the acute medical floor and confront the patients with the idea of further treatment. Each patient is given a letter from Dr. Nieder informing him of the Extended Treatment Program. A brochure describing the longer treatment is distributed to them. We are attentive to getting our message through, despite the patient's reluctance.

After nearly 20 years of working with alcoholic people, I have found one great barrier to the successful treatment of the alcoholic. The person himself is reluctant to acknowledge that he needs therapy or that he could benefit by it.

Recovering alcoholics on our



# Blue Cross-Blue Shield covers the program .....

medical unit often agree that our Extended Treatment Program sounds like a great idea—for someone else. Each of the many resistant patients has some alternate plan: he may say that he is certain he has taken his last drink . . . or that he will avoid the stress that upset him . . . or that he cannot afford to take three and a half additional weeks from work.

But for the patient who wants the Extended Treatment Program, the qualifications are minimal: he must be ambulatory, have minimum brain damage and be able to benefit from the experience.

A serious attempt is made to provide for the patient's com-

fort and to minimize the feeling of being institutionalized. Patients wear street clothes and are assigned lockers. There are generous visiting hours, hospital ground privileges, a weekend pass on the third weekend and evening meals in the cafeteria.

## Insurance Coverage

ETP is covered by Blue Cross-Blue Shield and many other insurance plans. For coverage, the patient must stay a minimum of 28 days in the alcoholism programs, beginning the day he is admitted to the hospital. If he is admitted to the detoxification unit, his first

of the 28 days is the day of admission.

Looking toward the future, Martha Washington Hospital's Alcoholic Treatment Center is planning a "night hospital," where patients can be treated in the evening, remain in the hospital over-night, and continue on with their daytime jobs and household duties. Our goal is to keep persons addicted to alcohol from further economic, health and social deterioration.

Through a comprehensive program of inpatient care, outpatient clinics, family counseling and follow-up treatment, we hope to enable alcoholic persons find satisfaction in their lives without drinking. ◀

## *Procedures for emergency commitment of alcoholic patients*

Your first step in dealing with an acutely-intoxicated, uncooperative patient is to persuade him—in a sympathetic but firm manner—to go to a designated hospital. Whenever possible, try to gain the resolved support of the patient's family.

However, if an intoxicated patient—whether or not he is an alcoholic—resists your advice, then you are empowered to have him forcefully admitted to a hospital by the Mental Health Code (January 1, 1969) of the Illinois Department of Mental Health.

The Mental Health Code rules apply to *all* physicians licensed to practice medicine in Illinois, including persons holding a State Hospital Permit or Temporary Certificate of Registration in the Medical Practice Act. In other words, this law is not limited to psychiatrists only.

When confronted by an uncooperative, acutely-intoxicated patient, you are empowered by the Code's section on emergency admission (article VII, page 12) to:

- advise the patient's spouse, or other inter-

ested person over 18 years of age, that he may obtain from a circuit court clerk a Petition #MHC-7, which states the reason for the hospitalization.

- based on your personal examination of the patient, made no more than 72 hours prior to admission, complete a Certificate of Need for Hospitalization (68-MHC-4), which must accompany the above Petition. This certificate states that the intoxicated and resistant patient requires immediate hospitalization and mental treatment.
- have the patient's spouse or other interested person present the above completed and signed forms to a policeman or other peace officer. The policeman is then authorized to apprehend the patient and transport him to a hospital that provides treatment for such persons and accepts involuntary emergency admissions.

Once the intoxicated patient has arrived at the hospital under duress, he may accept entering the hospital voluntarily. If he does, the involuntary detention ends.

# **“Do’s and Don’ts”**

## **of the**

Under Medicare law, a patient transferred to an extended care facility (ECF) is entitled to full coverage until the insurance carrier makes a decision on the patient’s claim!

Sound like a fairy tale? Well, it’s true! This and other interesting facts about Medicare ECF coverage were discussed at a recent meeting of the Illinois State Medical Society Committee on Aging and representatives of the Aetna Insurance Co.

# **Medicare Extended Care Facility program**

The following list of “DOs” and “DON’Ts” reveals *how* to insure this coverage for patients and will help you avoid problems and misunderstandings over other facets of the Medicare ECF program.

- DO advise the patient that your role in establishing a claim is limited to determining medical eligibility. The rest is up to the insurance carrier.
- DO advise the patient, or a member of his family, to call or visit the nursing home involved to make sure it is certified—and *will-ing*—to accept Medicare patients.
- DO make sure the patient has been hospitalized for three or more days and that he is transferred to the ECF within *14 days* of hospital discharge.
- DO see that an “admission notice transmittal” form is filled out and mailed to the insurance carrier within *48 hours* after the actual patient transfer. Unless this is done, the assurance of payment provision pending a claim decision does not apply.
- DO encourage a cooperative pre-discharge planning program between your hospital and ECFs. This results in satisfied patients and fewer problems for the facilities as well as physicians.

The information necessary to fill out the admission notice transmittal form, for instance, is contained in the hospital discharge form, the hospital discharge summary and your own orders for the patient. If a pre-discharge planning program exists, the necessary information can be transferred to the transmittal form by an employee of the hospital, or the ECF, or a portion by both. Your role can be limited to signing the form after you verify medical accuracy.

Hospital utilization review committees are often helpful in establishing pre-discharge planning programs.

- DO make sure that the information on the transmittal form and on follow-up progress notes are medically descriptive. The notes need not be extensive, but “patient improved” is not enough.
- DO advise the ECF that it can hire a charge nurse to supervise handling of Medicare records, including transmittal and other forms, and that the costs of hiring such an employee are chargeable to Medicare expenses.
- DON’T imply to the patient, by what you say or what you don’t say, that the patient will probably be eligible for Medicare benefits. Except for determining medical eligi-



bility, the responsibility rests with the insurance carrier or Social Security Administration.

- DON'T give up if a patient's claim is denied, retroactively or otherwise. A patient's eligibility can also be *reestablished retroactively* if the physician reconstructs medical necessity by reviewing his records.
- DON'T forget insurance carriers have medi-

cal consultants who can discuss particular cases. This can often prevent a waste of time and effort.

- DON'T be reluctant to invite insurance carrier representatives to county medical society meetings to discuss problems and misunderstandings. All carriers contacted by the committee said they welcomed the opportunity to meet with physicians.

### **Conclusion:**

The committee concluded that although Medicare regulations can be irritating, skilled nursing care is an important adjunct to a patient's health and well-being. When Medicare is dismissed as "tiresome regulations," it is the patient who may be hurt.

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## ***Erythropoietin isolation important to kidney disease patients***

The hormone that stimulates red blood cell formation—erythropoietin—has been isolated in pure form for the first time by researchers at The University of Chicago and the Atomic Energy Commission's Argonne Cancer Research Hospital (ACRH).

The achievement, which is potentially very important to kidney disease patients, was the work of Dr. Eugene Goldwasser, Professor of Biochemistry in the Division of the Biological Sciences and The Pritzker School of Medicine at the University, and Charles Kung, Senior Scientist at the ACRH.

The existence of erythropoietin has been known for at least 50 years, according to Dr. Goldwasser, but it is present in such minute traces that, until now, it has never been isolated in pure form.

The hormone must be in a pure state in order for researchers to study its chemical nature and use it in clinical trials. Once the chemical structure is known, it may be possible to produce it synthetically.

Anemic humans produce relatively larger amounts of erythropoietin, but excrete it in urine.

Kidney disease patients eventually may benefit greatly from the achievement since they do not produce the hormone and suffer severe anemia. The frequent transfusions which they require increase the risk of hepatitis and of a build-up of iron in the system.

If it were possible to treat them with pure erythropoietin, they might be able to lead a relatively normal life, much like a diabetic patient taking insulin, according to Dr. Goldwasser.

However, Dr. Goldwasser estimates that the cost of the treatment, initially at least, would be very great. To treat five patients would cost almost \$75,000, he said, meaning that it will be a long time before there is enough available for all who need it.



# new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Products**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

\* \* \* \* \*

A New Drug Application has been granted by the U.S. Food and Drug Administration for the following new drug.

**FUDR Cancer Chemotherapy** R  
**Manufacturer:** Roche  
**Nonproprietary name:** Floxuridine

The following new drugs have been marketed:

## DUPLICATE SINGLE PRODUCT

**VALADOL Tablets Analgesics-Nonnarcotic** o-t-c  
**Manufacturer:** Squibb  
**Nonproprietary name:** Acetaminophen NF  
**Indications:** Temporary relief of minor pain and fever.  
**Contraindications:** None mentioned.  
**Dosage:** Adult: 1-2 tablets 3 or 4 times daily  
Children 6-12 years: ½ to 1 tablet 3 or 4 times daily.  
**Supplied:** Tablets, 325 mg.

## COMBINATION PRODUCTS

**CONTROL-D Tablets Cold Preparations-General** R  
**Manufacturer:** SeMed  
**Composition:** Each tablet contains:  
Pseudoephedrine HCl 60 mg.  
Chlorpheniramine maleate 4 mg.  
**Indications:** Upper respiratory and bronchial congestion  
**Contraindications:** Hypersensitivity to either of the components, severe hypertension or coronary artery disease  
**Dosage:** One tablet 3 or 4 times daily  
**Supplied:** Tablets

**VASCORAY Diagnostics-Contrast Media** R  
**Manufacturer:** Mallinckrodt  
**Composition:** Each 25 or 50 cc. contains  
Meglumine iothalamate 52%  
Sodium iothalamate 26%

**Indications:** Intravascular angiocardiology, aortography and urography.

**Contraindications:** Cerebral angiography or in anuric patients

**Dosage:** Must be individualized according to body weight and type of study being done.

**Supplied:** Vials, 25 and 50 cc.

## NEW DOSAGE FORMS

**CONTROL-D Liquid Cold Preparations-General** R  
**Manufactured:** SeMed

**Composition:** Each 5 cc. contains  
Pseudoephedrine HCl 60 mg.  
Chlorpheniramine maleate 4 mg.

**Indications:** Upper respiratory and bronchial congestion

**Contraindications:** Hypersensitivity to either of the components, severe hypertension or coronary artery disease

**Dosage:** 5 cc. 3 or 4 times daily

**Supplied:** Liquid

## SORBITRATE

**Chewable Vasodilators-Coronary** R  
**Manufacturer:** Stuart

**Nonproprietary name:** Isosorbide dinitrate

**Indications:** Prevention and treatment of angina pectoris

**Contraindications:** History of sensitivity to the drug  
**Dosage:** Usual initial dose: 5 mg., adjust to patient's response.

**Supplied:** Chewable tablets, 5 mg.

## VALADOL

**Chewable Tablets Analgesics-Nonnarcotic** o-t-c  
**Manufacturer:** Squibb

**Nonproprietary name:** Acetaminophen NF

**Indications:** Temporary relief of minor pain and fever

**Contraindications:** None mentioned

**Dosage:** Children 6-12 years: 2 tablets 3 or 4 times daily

Children 3-6 years: 1 tablet 3 or 4 times daily

**Supplied:** Chewable tablets, 120 mg.

**VALADOL Liquid Analgesics-Nonnarcotic** o-t-c  
**Manufacturer:** Squibb

**Nonproprietary name:** Acetaminophen NF

**Indications:** Temporary relief of minor pain and fever

**Contraindications:** None mentioned

**Dosage:** Children 6-12 years: 2 tsp. 3 or 4 times daily.

Children 3-6 years: 1 tsp. 3 or 4 times daily.

**Supplied:** Liquid, each 5 cc. contains 120 mg.



**What regulations govern the signing of death certificates?**

**Can an RN "pronounce" a person dead?**

**Do nurses in nursing homes have authority to perform intravenous procedures, or dispense medications in a physician's absence but under his order?**

**Can a physician issue verbal orders for medications?**

## **Matters of Confusion:**

### **Death certification**

### **Performing IVs**

### **Dispensing medications**

Some physicians are confused over death certificate procedures and nurses are often reluctant to perform IVs or dispense medications because clear lines of authority have not been established.

The Illinois State Medical Society's Committee on Aging was directed to clarify these issues. The following information on state regulations was provided by Dr. Roger F. Sondag and Attorney Robert S. Gleason, both of the Illinois Department of Public Health. City regulations often supersede those of the state, so appropriate Chicago Health Department regulations are included. Physicians practicing outside Chicago should contact their own city health departments.

#### **Death Certification**

**Question:** Can a registered nurse "pronounce" a person dead?

**Illinois**—There are no state laws regarding "pronouncement" of death, but only a licensed physician or the coroner can sign a death certificate.

**Chicago**—City ordinances require that a deceased person be *pronounced* dead by a licensed physician signing the death certificate. The coroner can also sign the death certificate.

**Question:** Can a body be removed from a nursing home before the death certificate is signed?

**Illinois**—"Yes," according to Dr. Sondag. "Say a person dies at 3 a.m.; the nurse calls the physician. In turn, the physician tells the undertaker: 'I will sign the death certificate in the morning.'"

"The nurse stated time of death at 3 a.m., and charted the same," Dr. Sondag said. "The body was actually released from the nursing home before the death certificate was signed. This can be, and is done."

**Chicago**—Bodies cannot be removed until the physician who attended the deceased during his last illness pronounces the person dead by signing the death certificate. Until this is done, nursing homes must provide a room in which to store bodies for a period not to exceed 36 hours.

**Question:** Can RNs start IVs in the absence of the physician, but at his request?

**Illinois**—"Yes," according to Dr. Sondag. "But this should be spelled out in the written policies of the facility and in the job description of the RNs."

**Chicago**—City regulations specify that all medications and treatment must be based on the *written* order of the physician. However, a prescription filled by a druggist at the physician's request is defined as a "written" order. A *verbal*

order via telephone is acceptable in an emergency. The nurse must log the order, and it must be countersigned by a physician within 30 days. **Question:** Can LPNs dispense medications or perform IVs?

**Illinois**—"Yes." Dr. Sondag says. "When the definition of a nurse was revised it included LPNs as well as RNs. Here again the facility may wish to restrict these duties, and if so, it should be clearly stated in written policies and job descriptions."

**Chicago**—All nurses must have training or experience, or both, in *practical* nursing, and are

under the general supervision of a nursing director. Such nursing personnel are authorized to dispense medications or perform treatments prescribed by a licensed physician.

### Conclusions

**A death certificate may be signed by the physician the morning after death occurs. The authorized duties and responsibilities of nursing personnel should be clearly spelled out by nursing homes in written policies and job descriptions.**

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## June clinics for handicapped children

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will hold 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- June 1 East St. Louis—Christian Welfare Hospital
- June 2 Rock Island Cerebral Palsy—3808 Eighth Avenue
- June 2 Carmi—Carmi Township Hospital
- June 2 Hinsdale—Hinsdale Sanitarium
- June 3 Sterling—Community General Hospital
- June 3 Effingham—St. Anthony Memorial Hospital
- June 3 Lake County Cardiac—Victory Memorial Hospital
- June 8 East St. Louis—Christian Welfare Hospital
- June 8 Peoria—St. Francis Children's Hospital
- June 9 Champaign-Urbana—McKinley Hospital
- June 10 Springfield—St. John's Hospital
- June 10 Rockford—St. Anthony Hospital
- June 11 Chicago Heights Cardiac—St. James Hospital
- June 15 Belleville—St. Elizabeth's Hospital

- June 15 Rock Island Area General—Moline Public Hospital
- June 16 Chicago Heights General—St. James Hospital
- June 17 Bloomington—Mennonite Hospital
- June 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
- June 22 Danville—Lake View Hospital
- June 22 Peoria—St. Francis Children's Hospital
- June 23 Aurora—Copley Memorial Hospital
- June 23 Springfield Pediatric Neurological—Diocesan Center
- June 25 Chicago Heights Cardiac—St. James Hospital
- June 25 Evanston—St. Francis Hospital
- June 28 Peoria Cardiac—St. Francis Children's Hospital
- June 29 Alton—Alton Memorial Hospital

Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.





## the doctors library

**Hernia Repair Without Disability.** By Lichtenstein, I. L. The C. V. Mosby Company, St. Louis, 1970. \$26.50.

Rather than reiterate all the various techniques for repairing groin hernias, this author describes in great detail the rationale, technique, and results of his methods of hernia repair. Beginning with an excellent description of the surgical anatomy of the inguinal region, Dr. Lichtenstein presents a careful analysis of each step in his "one day" hernia repair. This technique emphasizes the following details:

1. Local infiltration anesthesia or differential epidural block is used. In addition to avoiding the complication of a general inhalation anesthesia, this allows the surgeon to test the integrity of the repair by having the patient perform a Valsalva maneuver.
2. The inguinal floor is repaired by approximating the transversus abdominis aponeurosis (not the transversalis fascia) to Poupart's ligament with heavy Teflon-Dacron sutures.
3. A medical suture approximates the transversus aponeurosis to the pubic tubercle, thus strengthening the area where most direct recurrences occur.
4. Sutures lateral to the spermatic cord are omitted for the author feels this interferes with the shutter mechanism at the internal ring.
5. A plastic mesh screen is inserted in all recurrent and direct hernias.
6. The external oblique aponeurosis is closed without imbrication beneath the cord.
7. Skin sutures or clips are replaced by adhesive bridges within 24 hours.

Using this technique all patients walked from the operating table and 98% were discharged within 24 hours of surgery without any restriction of physical activity. Of the 627 hernias repaired by the author and followed from one to

nine years, only 15 reoccurred, and nine of these were repairs of recurrent hernias.

Certainly all surgeons will not agree with this technique. In particular, the disciples of McVay will be dismayed by the author's total disregard of the transversalis fascia. However, this outstanding cure rate speaks well for the author's technique. One is tempted to conclude that consistent results in hernia repair are determined more by the surgeon's expertise and familiarity with the inguinal region than by any one particular technique. In this regard, all surgeons will benefit from this clear and expert review of both the inguinal anatomy, and the pathology of groin hernia.

Stuart M. Poticha, M.D.

### **Corticosteroids in the Treatment of Shock.**

By Schumer, William and Nyhus, Lloyd M. Published for the College of Medicine, Department of Surgery, by the University of Illinois Press, Urbana, Chicago, London, 1970. \$10.

The purpose of the text, edited by Drs. Schumer and Nyhus, is "to emphasize the fusion of basic and clinical sciences in the complex study of shock." In addition to reading this fine text, the reviewer had the privilege of attending the symposium from which it was obtained. The symposium and the text are truly multidisciplinary in their approach to the basic and clinical material concerning shock and more specifically to the usage of corticosteroids in its treatment. Each of the authors presents not only background information concerning laboratory investigation into the use of corticosteroids in the treatment of shock, but also current concepts on the why and how of clinical usage. The multidisciplinary approach covers this complex field in considerable detail from the viewpoint of

many specialties. Since the final answer concerning the use of steroids in shock is not clear-cut, the authors present the material in a fashion that will enable the reader to arrive at his own conclusions. The second section of the book, a series of questions and answers, again points out the tremendous controversy that exists in this field. It gives each of the authors an opportunity to re-express and re-emphasize their opinions on specific points concerning etiology and therapy of shock.

This monograph on the use of corticosteroids in the treatment of shock is clear, concise, and certainly brings a most interesting and difficult problem into relatively clear focus. The reader is then left with arriving at his own decision as to the proper indications for administering steroids to the patient in shock.

Julius Conn, Jr., M.D.

**Appraisal of Current Concepts of Anesthesiology, Volume IV.** Edited by John Adriani. 1968.

The appearance of the fourth volume of this series must surely attest to the appeal of this type of book. Unfortunately, it is an appeal which has entirely escaped this reviewer.

Of the twenty-six contributors, including the

distinguished professor of surgery from Tulane, no clue is offered as to which authority is responsible for which chapter. The editor points out that the subject matter occupies an intermediate position between medical journals and textbooks, and that the reviews are "intended for clinicians." Very little new information that is not available in standard texts is presented on those subjects of clinical concern. Little knowledge or clinical usefulness emerges from the chapter on alcohol withdrawal syndrome, where this information or management would be most welcome. Space does not allow specific criticism of each chapter, but the kind of information offered in this volume is best conveyed at seminars and tutorials held by each residency program. Perhaps such seminars are the source of this material. There is no substitute for such sessions, and there should be no need for one. Those who are unable to "keep abreast" of present day literature now have to face the additional problem of keeping abreast with the various current reviews of the literature. This requires that a selection be made by the readers between this text and others currently available. It would seem then that the potential benefits of such publications might be more carefully scrutinized.

John Homi, M.D.

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## *Three Illinois journalists named recipients Of ISMS Journalism Fellowships*

Three Illinois journalists have been named 1971 recipients of Illinois State Medical Society Journalism Fellowships, according to Dr. J. Ernest Breed, ISMS president.

Recipients are Judy Brandes, of Paddock Publications, Inc., Arlington Heights; Dorothy L. Buresh, of *The Daily Dispatch*, Moline; and Gordon Matthews of the *Champaign-Urbana News Gazette*.

The fellowships were created by the society's Public Relations Council to advance the quality of medical writing in non-metropolitan newspapers, according to Dr. Matthew Eisele, Council chairman. The program is now in its fifth year.

Miss Brandes, a daughter of a Columbus, Ohio general practitioner, has been with Paddock Publications for two years. She is the education and medical writer.

She developed an interest in medical writing after reading medical journals in her father's office where she worked during summer vacations. She believes the news media needs "more accurate and responsible coverage of medical topics."

Mrs. Buresh writes a weekly column entitled, "Bits from a Battered Beat" for the *News-Dispatch*. She also covers news of medicine, industry and business. She won an ISMS Medical Journalism Award in 1967.

Mr. Matthews has worked for the *Champaign-Urbana News Gazette* for the past seven months. A native of Bismarck, Illinois, he earned a degree in journalism from the University of Illinois in 1970. His duties include coverage of medicine, education and service clubs.



## Obituaries

\***Garnet Bradley**, West Virginia, died April 10, at the age of 58. She was formerly a Chicago psychiatrist.

\***Charles J. Caul**, Dolton, died March 19, at the age of 57.

\***Murray F. Fuchsman**, Chicago, died March 26, at the age of 81. He was a member of the ISMS Fifty Year Club.

\***Hyman S. Green**, Wilmette, died March 31, at the age of 69.

**Roy Preston Garrett**, Chicago, died March 13, at the age of 74.

\***Lawrence Jacques**, Chicago, died March 23, at the age of 72. He was founder and chairman of the Civic Medical Center of Chicago.

\***David Johnson**, Los Angeles, formerly a Chicago South Side surgeon, died March 10, at the age of 71.

**George Gail Moore**, Benton, died March 20, at the age of 82.

\***Milton M. Ochs**, Oak Park, died March 27, at the age of 75. He was a member of the ISMS Fifty Year Club.

\***Nino Pellettieri**, River Forest, died March 21, at the age of 65.

\***Ernest Schwarz**, Chicago, died in April at the age of 80.

\***Alfred A. Strauss**, Palm Springs, Calif., died April 1, at the age of 90. He was a founder of the Louis Weiss Memorial Hospital and a research pioneer in gastro-intestinal and cancer-related surgery. He was also a member of the ISMS Fifty Year Club.

\***Edward V. Zaeske**, Rock Falls, died March 13.

\***Chester R. Zeiss**, Glendale, Calif., died March 9, at the age of 62.

\*Denotes member of Illinois State Medical Society.

### On the Cover

An African violet plant graces this month's cover—*Saint-paulia ionantha*. Cover photo by Mike Ahearn.

**Brief Summary of Prescribing Information—**9-9/22/69. For complete information consult Official Package Circular.

**Indications:** Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

**Contraindications:** Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

**Warnings:** Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

**Precautions:** Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

**Adverse Reactions:** Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

**Usual Dose:** 1 tablet b.i.d.

**Supplied:** Bottles of 60, 600, and 1000 scored 50 mg. tablets.

# Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

**BRISTOL** BRISTOL LABORATORIES  
Division of Bristol-Myers Company  
Syracuse, New York 13201

# Seconal<sup>®</sup> Sodium

## SODIUM SECOBARBITAL

Seconal Sodium generally provides tense, nervous, worried patients a good night's sleep. It brings restful slumber within fifteen to thirty minutes. The soporific effect lasts for five to seven hours . . . usually dissipates long before the individual awakens. Most patients wake up refreshed and ready for another day. When you prescribe Seconal Sodium, your patients will appreciate the rest.

### SECONAL<sup>®</sup> SODIUM (SODIUM SECOBARBITAL)

**Indications:** Insomnia; sedation in obstetrics, neuropsychiatry, and dental procedures or whenever a rapid-acting sedative or hypnotic effect is desirable.

**Contraindications:** Except in emergencies, do not give to persons likely to become dependent on such medications. Do not administer in the presence of uncontrolled pain or to persons with a history of porphyria.

**Warning:** May be habit-forming.

**Precautions:** Use with caution in patients with decreased liver function.

**Adverse Reactions:** Idiosyncrasy (excitement, hangover, pain) may appear. Hypersensitivity reactions may occur, especially in patients with asthma, urticaria, or angioneurotic edema.

**Dosage:** *Adults*—Insomnia, 100 mg. at bedtime. Preoperatively, 200 to 300 mg. one to two hours before surgery. *Older Children*—50 to 100 mg.

**Overdosage:** *Symptoms*—C.N.S. depression. *Treatment*—Gastric lavage; administration of I.V. fluids; maintenance of blood pressure, body temperature, respiration; dialysis.

**How Supplied:** Enseals<sup>®</sup> (enteric-release tablets, Lilly) Seconal<sup>®</sup> Sodium (sodium secobarbital, Lilly), 100 mg. (1½ grains), in bottles of 100.

Pulvules<sup>®</sup> Seconal<sup>®</sup> Sodium (Sodium Secobarbital Capsules, U.S.P.), 30 mg. (½ grain), in bottles of 100 and 500; 50 mg. (¾ grain) and 100 mg. (1½ grains), in packages of 100, 500, and 5,000.

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*Additional information available upon request.*

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# ILLINOIS STATE MEDICAL SOCIETY

360 north michigan avenue

chicago, illinois 60601

phone (312) 782-1654

Dear Fellow Doctor:

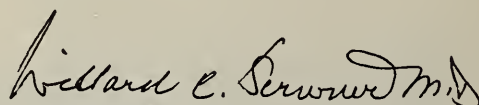
This year the United States Savings Bond program observes its 30th anniversary. It marks not only the birthday of a great national thrift habit, but also something of a patriotic milestone for organizations like ours whose support has helped to bring the program to its present level of success.

Americans now own a collective nestegg of over \$52 billion in Series E and H Bonds - and this is only the part that remains after tens of billions of dollars in additional Bond holdings have already been spent to finance college educations, new homes, and other impressive investments in better living.

If any of this \$52 billion represents your own holdings, I don't need to tell you what a wise thrift choice you have made. But if you don't own Savings Bonds, this is surely a good time to start buying them - not because it's the 30th anniversary, but because Bonds today are better than ever. All E Bonds issued since June 1, 1970, will pay an interest bonus of  $\frac{1}{2}\%$  if they are held to maturity of 5 years 10 months, making the over-all rate to maturity  $5\frac{1}{2}\%$  (4% the first year). This, with the many other proven features such as safety, liquidity, and tax advantages, makes today's Bonds an unusually good way to save for the needs of the future.

The Payroll Savings Plan where you work, and the Bond-a-Month Plan at your bank, make savings easy and automatic. Buying today's U.S. Savings Bonds makes it rewarding - not only for yourself, but for your country. Won't you think it over?

Sincerely,



Willard C. Scrivner, M.D.  
Chairman, Board of Trustees

## Halotestin® (fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.

**Indications** *Male*: Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female*: Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females*: In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelocystic sclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias. **Contraindications** Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

**Precautions** Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

**Adverse reactions** Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

**Supplied Tablets**: 2 mg., scored—bottles of 100./5 mg., scored—bottles of 50./10 mg., scored—bottles of 50.

For additional product information, see your Upjohn representative or consult the package circular.

**Upjohn** The Upjohn Company, Kalamazoo, Michigan

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MED 8-5-S (LQX)

## World Health Organization fellowships available to United States health workers

The World Health Organization will make available in 1972, a limited number of short-term fellowships for travel abroad related to the "improvement and expansion of health services" in the United States. This support is for United States citizens engaged in operational or educational aspects of public health.

In selecting applications, a special committee will consider the professional background of the individual, the field and locale of the study proposed, and the utilization of the experience by the applicant on his return. Employees of the Federal Government are not eligible. Applications will not be considered for the pursuit of pure research projects, for attendance at international meetings, nor from students in the midst of training at either the undergraduate or graduate level. Applicants may not be more than 55 years of age.

A fellowship award will cover per diem and transportation. Except in very unusual circumstances, it will be limited to short-term travel programs averaging about two months. Employers of successful applicants will be expected to endorse applications and to continue salary during the fellowships.

Priorities of award will be established up to the total of the funds available. The deadline for the receipt of completed applications is September 30, 1971.

Further information may be obtained from Dr. Robert W. Jones, III, Chief, Foreign Students Education Branch, Bureau of Health Manpower Education, National Institutes of Health, Public Health Service, Room 1014, HEW-S, Washington, D.C. 20201.





## editorials

### "Caution — living may be hazardous . . . . ."

During the past ten years the laity has been scared by the alleged health hazards of cranberries, cyclamates, saturated fats, monosodium glutamate, insecticides, air pollution, mercury, and the fearsome four—alcohol, coffee, tea, tobacco. Information of this type usually makes headlines because it is of interest to the public. All too often the report is premature or cannot be substantiated. But the information does not originate with the news media. It comes from a variety of sources, including our profession.

The medical fraternity is loaded with opinionated physicians and surgeons who make off-the-cuff remarks to the press without regard to the consequences. They may regret what they said after seeing it in print or hearing it over the air. Those wanting publicity are likely to justify anything that was said.

A similar problem exists among many professors in the basic sciences who report on the health dangers of pollution, contamination and chemicals in food. Public health officers may do the same and more so when they have an axe to grind. A recent example of this was the statement by a National Cancer Institute scientist who said that if we allow the SST to fly over our country, the number of skin cancers would increase from a low of 23,000 to 103,000 cases.

Statements based on opinions usually are the most startling and likely to reach the newsroom.

The remarks become beliefs that may persist for years, even though not substantiated; now and then it takes a lot of time and money to disprove a theory.

Irresponsible journalists are sometimes to blame, especially when they fail to check the reputation of the "authority" or how he reached certain conclusions. It is easy for the reporter to shuck the responsibility (but not too often). When questioned by his editor, he replies, "This is what the doctor said," or "If doctor so-and-so wants to make an ass of himself, let him."

Wilbur Cross, writing in the November 1970, issue of *Private Practice*, has collected a number of amusing reports relative to the effects of various activities on our health. The article is entitled, "Caution—living may be hazardous to your health." He includes warnings about the good or bad effects of a number of things on baldness, jogging, bed rest, and health in general. We have been warned about so many foods and food additives that people no longer know what to eat.

We recently read a headline, "Illness can strike when you dream." Life is full of risks but most of us are willing to take our chances. But we are getting a bit tired of being reminded of this.

T. R. Van Dellen, M.D.

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## Calling for the prevention of aquatic accidents

There has been a wave of interest in aquatic sports in the past decade. With the increase in the number of boats in Illinois waters, a rise in boating accidents is not surprising. Kenneth

Gruenewald, Illinois Department of Conservation, has compiled the 1969 boating accident report for Illinois. The report lists 101 boating accidents, with 42 fatalities for all waters. There

were 37 drownings and five deaths from multiple injuries and shock. Fifty-four additional injuries to boaters were also recorded; the most common type of accident resulting from a collision between two vessels. Falls overboard accounted for six drowning victims. Water skiing accounted for six accidents, but no fatalities.

With doctors and their families taking to the lakes in record numbers, a listing of the safety rules for boaters seems appropriate.

1. Check out all equipment, including life-saving equipment and fuel.
2. Know the meaning of buoys; what they mark and indicate.
3. Know the various disaster signals.
4. Keep to the right when meeting another boat.
5. Give right of way to vessels approaching in your danger zone on the starboard (right)

side. If necessary, slow down, stop or reverse, or turn right so crossing the stern (rear) of the other craft.

6. Hold your course and speed when you are being passed or when approached by another boat from your port (left) side. Be prepared to take action, to avoid collision, if the approaching craft fails to yield the right of way.
7. Don't turn a small craft at high speeds—it may be swamped by its own wash.
8. Stay clear of large vessels; their wash can upset a small boat.
9. Children must stay in their seats and should never sit on the sides of the boat; they should use life vests.
10. Approach the dock or mooring against the wind or current (whatever is strongest).

H. Kravitz, M.D.

## Mrs. Frances Zimmer retires

Mrs. Frances C. Zimmer, "First Lady" of ISMS retired on March 30, after over 35 years of service.

Mrs. Zimmer joined the Society in 1935, when the headquarters were located in Monmouth, Illinois, and staffed a two-man office. When the office was relocated in Chicago, in 1960, Mrs. Zimmer moved with it and served in the capacity of Executive Assistant.

She now resides in Laguna Hills, California, where she is working toward her Congressional Certification in Braille, and directing her attention toward her long-time interest in photography.



Mrs. Francis Zimmer



Mrs. J. Ernest Breed

## Mrs. Breed succumbs to illness . . .

Mrs. Genevieve Shepard Breed, wife of ISMS President J. Ernest Breed, M.D., died April 24, following a long-term illness.

Born and reared in Columbus, Kansas, she graduated from the College of Emporia in 1926 and married Dr. Breed in June, 1926.

Mrs. Breed was active in a number of women's clubs including the Auxiliary to ISMS and served as chairman of the Drama Department of the Conference of Club Presidents and Program Chairmen.

She is survived by her husband, and three sons, Allen, Gordon, and David, who own and operate the Breed Corporation of Fairfield, New Jersey. In addition, there are eight grandchildren.





## report

a service of the illinois medical assistants association

### *Positive mental attitude a "must" for us*

THELMA PELOW/DEKALB COUNTY CHAPTER

I recently heard a program on "Attitude" by Earl Nightingale. Everyone young and not so young should hear it, not once but many times, because the one word "attitude" could be the dynamic key to our lives. We would be happier people if we heeded the word and lived by it.

By being a happier person, you radiate and spread to those around you, thereby influencing their attitude toward you. Mr. Nightingale explains, "Attitude is the feeling and mood of yourself toward others which in turn determines the actions, feelings and moods of others towards you." We must live our life in the right manner in order to make our life a success.

The Medical Assistant is an open target for criticism from the public and patient who sit in a doctor's office, hospital or clinic waiting to be seen. They have the best advantage to observe you, the Medical Assistant, the real you in action, answering phone calls, taking payments, arranging admissions to various departments such as the lab, X-ray or hospital, and answering patient's questions. You are the "target of observation" at all times. How is your attitude? Is there room for improvement? Could you have

handled that situation more effectively?

The Medical Assistant must train and discipline herself in order to achieve a positive mental attitude. We must concentrate on overcoming negative attitudes, such as pettiness, jealousy, anger and even the "silent treatment." These are unbecoming to all of us but especially the Medical Assistant. It is not easy; it will be a struggle to achieve but the results will be rewarding.

Illinois Medical Assistants urge you to have a positive attitude toward life and through seminars, educational forums and other forms of idea exchanges we will help you toward a more productive, happier life. Medical Assistants cannot afford to be unhappy, inconsiderate, depressed people. Our employers cannot afford to have such a person in contact with their patients. Try attending a local chapter meeting and see for yourself how a positive attitude in life will project a good attitude between your doctor employer and his patients.

For further information contact Mrs. Vivian Kraft, R.R.#2, Normal, Illinois, 61761 or Mrs. Norma Domanic, 150 Ash Street, New Lenox, Ill. 60451.

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#### **Urban renewal or removal?**

**Instead of improving the nation's urban housing problems, certain HUD programs have actually reduced the number of living units. The General Accounting Office reports that in 324 cities surveyed, HUD demolished 214,000 dwellings for low and moderate income families, building only 124,000 replacements.**

## Dimetapp Extentabs®

**INDICATIONS:** Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

**CONTRAINDICATIONS:** Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

**WARNINGS:** *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

**PRECAUTIONS:** Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

**ADVERSE REACTIONS:** Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

**HOW SUPPLIED:** Light blue Extentabs in bottles of 100 and 500.

## Omphalomesenteric....

(Continued from page 496)

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## Gardner's Syndrome

(Continued from page 513)

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17. Gordon, W. Cal, Jr., Capt., Rast, M. F. and Whelan, T. J., "Gardner's Syndrome," 155:538, 1962.



# *Abstracts of Board actions*

*(Continued from page 478)*

5. Commended the Governor for his steps to improve the enforcement of nursing home standards and called for continuing efforts to upgrade these institutions.
  6. Supported a University of Illinois program for exposing undergraduate pre-medical students to the practice of medicine through field trips to hospitals and clinics.
  7. Approved the following legislative proposals:
    - a. Requiring plaintiff to post bond before instituting malpractice proceedings.
    - b. Extending the Good Samaritan concept into the emergency room.
    - c. Prohibiting home rule units from concurrent licensing of professions already licensed by the state.
    - d. Allowing a physician licensed to practice medicine and surgery in another state to practice medicine in Illinois for a six-month period, until licensed in Illinois.
  8. Urge ISMS committee members not to proceed with lobbying activities involving legislation that has not received action by an official body of the Society.
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## *New materials on hypertension Issued by Heart Association*

**"Mechanisms of Hypertension, 1970,"** the proceedings of two-day scientific sessions held by the American Heart Association's Council for High Blood Pressure Research, are now available in book form.

Issued as Volume 18 in the Hypertension Series, the book deals with medical problems related to hypertension and will be of special interest to physicians and researchers in the hypertension field, as well as internists, cardiologists, medical libraries and medical schools.

Earlier volumes in the series dating from 1961 onward are available from the AHA National Office at reduced prices.

Also in this area, a table-top **"Diagnostic Testing Unit on Hypertensive Disease"** has been prepared by the Heart Association for use at medical meetings, as a teaching exercise for medical students and house officers, and as a basis for discussion at hospital staff meetings.

The unit's four panels illustrate pertinent laboratory data on four patients. After reading their case histories and studying the panel's X-rays, eyegrounds and electrocardiograms, the physician fills out a multiple choice questionnaire concerning each case. An accompanying 14-page booklet contains instructions for testing, case histories and questions and answers.

The 10-pound unit may be obtained on a loan or purchase basis from local Heart Associations or the AHA Central Office, 44 E. 23rd St., New York, N.Y. 10010.



# socio-economic news

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a service of the division of health care delivery

By JOSEPH J. LOTHARIUS

## **Blue Shield loses Medicare contract**

Delays in claims processing are costing Blue Shield its Medicare (Part B) contract in four of the five Illinois counties in which the company has administered the physician's portion of the program since 1967. The Social Security Administration announced that Continental Casualty Company would assume fiscal responsibility for Medicare (Part B) in Kane, Lake, DuPage and Will counties. Blue Shield will continue to administer Medicare in Cook County. The change means Continental will administer Medicare in all of Illinois except Cook County.

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## **Will Medicare Increase payments To physicians?**

Rumors persist that Medicare payments to MDs will be increased—effective July 1, 1971—to reflect 1970 fee profiles. Thus, for the second time in less than six months the Social Security Administration may authorize its Medicare carriers to update fee profiles. The last updating to 1969 levels became effective last January 1.

Questions yet to be answered regarding the rumors are: Will the SSA authorization include a directive to reduce the area prevailing or customary fees? If it does, the apparent increase may be meaningless. Also, are both Part B Medicare carriers in Illinois—Continental Casualty Company and Blue Shield—prepared to make the changeover on their computer systems in time to meet the July 1, starting date?

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## **No endorsement for DVR payment plan**

ISMS Trustees failed to endorse the new payment proposal of the Illinois Division of Vocational Rehabilitation (DVR). The Department said it was extending its limits of payment to reach the usual fees of at least 70% of Illinois physicians. Alfred Slicer, DVR Director, said if ISMS concurs he would implement the program in March with the approval of the Bureau of the Budget.

ISMS Trustees expressed appreciation to DVR for its efforts to improve payment to MDs. Formal endorsement



was withheld, however, because the plan fails to fully meet the usual, customary and reasonable fee criteria established by the House of Delegates.

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## **HEW asks help From insurance industry**

An alliance between government and the private health insurance industry to develop a national health care program has been proposed by John G. Veneman, Jr., Undersecretary of HEW. Mr. Veneman said he did not believe the Federal government "should dominate the health system." He added: "We believe there is a place in that system for private health insurance groups and for private practice." He emphasized the importance of finding the means to increase health services and to improve their distribution.

Veneman said the two routes available to achieve this goal are lesser desirable federal intervention and control, or "promote and encourage a health maintenance industry—an innovative, pluralistic competitive industry—that is self-regulating and is capable of making its own investment decisions." He said the latter is the method preferred by HEW.

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## ***"MEDIHC Messenger" lists corpsmen seeking civilian medical positions***

Doctors with staffing problems whether they be in private practice or clinics can now find capable service corpsmen who have received extensive training and experience in the various medical specialty areas.

The *MEDIHC Messenger*, a monthly compendium of servicemen desiring civilian medical positions, is available through the Health Careers Council of Illinois.

Since its inception in October, the *Messenger* with its resume-type listings of medically trained servicemen has, according to Joseph Foley, HCCI assistant director, "immediate application to the work and staffing problems of the independent physician or doctor working in clinical medicine . . . these corpsmen are often uniquely suited to such medical practice."

Corpsmen listed in the *MEDIHC Messenger* vary in their skills from those of the orderly type, on up to those qualified to assist a doctor in treatment, to certified laboratory technologists, to men with several decades of medical administrative experience.

The newsletter provides doctors with explicit job information along with job expectations, an address and phone number.

Persons interested in receiving additional information about the program should contact the Health Careers Council of Illinois, 410 N. Michigan Ave., Chicago 60611, 312-467-0900.

# When Preventing Constipation is a Concern...

Consider

## SURFAK<sup>®</sup>

dioctyl calcium sulfosuccinate  
(stool softener)

### Surfak prevents constipation:

#### ■ naturally

- ... without bowel distention
- ... without adding sodium to the system
- ... without requiring unusual intake of water

#### ■ conveniently—one 240 mg capsule per day

#### ■ economically—costs less per effective daily dose\*

Supplied: Bottles of 15, 100 (FSN 6505-926-8844) and 1000 (FSN 6505-890-1627) and Unit Dose 100's (10 x 10 strips).

\*based on actual drug store survey of prescribed dosages



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PHARMACEUTICAL CO.  
Somerville, N.J. 08876 U.S.A.



# Professional Film List

(Distribution limited to members of medical and allied professions.)

(Available only in 16 mm.)

- |   |  |
|---|--|
| 1 GRAND ROUNDS® #1 .....55 minutes (B & W)  | nephrectomy/kidney   |
| "Diagnosis and management of acute abdominal problems" (Released 1956)                      | transplantation" .....23 minutes (Color)   |
| 2 GRAND ROUNDS #2 .....80 minutes (B & W)   | (Released 1966)  |
| "The cardiac patient in stress: work, surgery, pregnancy" (Released 1956)                   | 23 "Myocardial revascularization   |
| 3 GRAND ROUNDS #3 .....74 minutes (B & W)   | —Vineberg procedure" .....19 minutes (Color)   |
| "The borderlines of cancer; problems in the management of doubtful lesions" (released 1956) | (Released 1966)  |
| 4 GRAND ROUNDS #4 .....84 minutes (B & W)   | 24 "The obsolete menopause" .....18 minutes (Color)  |
| "Pre-malignant and malignant lesions of the breast and colon" (Released 1957)               | (Released 1966)  |
| 5 GRAND ROUNDS #5 .....79 minutes (B & W)   | 25 "Locomotion of cancer cells in vivo compared with normal cells (time-lapse cinemicrography)" .....21 minutes (Color)  |
| "Diagnostic and therapeutic advances in liver disease" (Released 1957)                      | (Released 1967)  |
| 6 GRAND ROUNDS #6 .....80 minutes (B & W)   | 26 "Cold-light endoscopy" .....21 minutes (Color)  |
| "Three key questions in coronary disease" (Released 1957)                                   | (Released 1968)  |
| 8 GRAND ROUNDS #8 .....82 minutes (B & W)   | 27 "Lillehei on stagnant shock" .....21 minutes (Color)  |
| "Clinical problems in chest diseases" (Released 1959)                                       | (Released 1968)  |
| 9 GRAND ROUNDS #9 .....81 minutes (B & W)   | 28 "The technique of intra-articular and peri-articular injection" .....20 minutes (Color)   |
| "Gastrointestinal problems: medicine, or surgery?" (Released 1960)                          | (Released 1969)  |
| 10 GRAND ROUNDS # 10 .....three segments (B & W)  | 29 "X-ray, ultrasound, and thermography in diagnosis" .....22 minutes (Color)  |
| "Lesions of the brain"  | (Released 1969)  |
| 10A Stroke (37 minutes)   | 30 "Lubrication in healthy and arthritic joints" .....15 minutes (Color)   |
| 10B Head injury (28 minutes)  | (Released 1970)  |
| 10C Parkinsonism (24 minutes) (Released 1961)   | 31 "Clinical applications of lasers" ....19 minutes (Color)  |
| 14 Kay-Anderson #1 .....20 minutes (Color)  | (Released 1970)  |
| "Open-heart surgery using the Kay-Anderson heart-lung machine" (Released 1958)              | 32 "Medical potential of lasers" .....21 minutes (Color)   |
| 15 Kay-Anderson #2 .....23 minutes (Color)  | (Released 1971)  |
| "Two original open-heart operations" (Released 1959)  |  |
| 16 Kay-Anderson #3 .....20 minutes (Color)  | You can arrange for a free booking of any one of the film titles on the above list by circling the number corresponding to the title you want. Show your preferred showing date, be sure to print or type your name and address. Please contact us by letter with complete details if more than one booking date is desired. |
| "Diagnosis of ventricular septal defects" (Released 1960)                                   | If you want free full-color posters to help publicize your showing, indicate the number desired.   |
| 17 "No real pathology" .....19 minutes (B & W)  |  |
| (Released 1962)   |  |
| 18 "Diabetics unknown" (lay) .....23 minutes (B & W)  |  |
| (Released 1962)   |  |
| 19 "Hypnosis as sole anesthesia for cesarean section" .....25 minutes (Color)               |  |
| (Released 1963)   |  |
| 20 "Twelve authorities evaluate fluoride" .....29 minutes (Color)                           |  |
| (Released 1963)   |  |
| 21 "Visceral organ transplants" .....30 minutes (Color)                                     |  |
| (Released 1966)   |  |
| 22 "Renal hypertension/bilateral  |  |

DESIRED SHOWING DATE:  
ALTERNATE SHOWING DATE:  
NAME AND ADDRESS (PLEASE PRINT OR TYPE)  
ZIP CODE:

1	2	3	4	5	6	8	9
10A	10B	10C	14	15	16	17	18
19	20	21	22	23	24	25	26
27	28	29	30	31	32		

PLEASE ALLOW AT LEAST 4 WEEKS FROM DATE OF REQUEST TO SHOWING DATE.  
POSTERS

Send to: Upjohn, Professional Film Library, 7000 Portage Road, Kalamazoo, Mich. 49001.

# what goes on

## a guide to continuing education

### May 19—Diabetes Association of Greater Chicago

#### *"Newer Understanding of Insulin Secretion in Health and Disease"*

Ann M. Lawrence, M.D., Assoc. Prof. Department of Medicine, University of Chicago, Pritzker School of Medicine.

Little Company of Mary Hospital, Shinner Auditorium, 2800 W. 95th St., Evergreen Park

### May 24-26—Wisconsin Heart Association

#### *Annual Scientific Sessions for Physicians* *"An Appraisal of Coronary Surgery 1971"*

The sessions are designed to present, discuss and criticize present diagnostic approaches, surgical techniques and their results.

The sessions are sponsored by the Wisconsin Heart Association and the American Heart Association's Council on Clinical Cardiology and Council on Cardiovascular Surgery.

Topics to be presented are:

"Aorta-Coronary Vein Bypass Grafts"

"Coronary Collaterals—Natural Revascularization?"

"The Value of the Carotid Sinus Nerve Stimulator (Angistat)"

"An Appraisal of Coronary Surgery"

Registrants will have an opportunity to meet with experts and discuss case problems of their own.

Milwaukee Expo, Milwaukee, Wisconsin

### May 28—Illinois State Psychiatric Institute & Institute for Juvenile Research

#### *Family Therapy Seminar*

#### *"New Directions in Family Therapy"*

Frederick Duhl, M.D., Director, Boston Family Institute  
Auditorium, 1601 W. Taylor St., Chicago/  
1:30 p.m.

### June 1—Illinois State Psychiatric Institute & Institute for Juvenile Research

#### *New Perspectives Seminar*

#### *"Will the Real Helping Professional Please Stand Up?"*

Robert S. Mendelsohn, M.D., Assoc. Prof. of Pediatrics & Community Health, University of Illinois at the Medical Center

Auditorium, 1601 W. Taylor St., Chicago/  
2:30 p.m.

### June 11—Association for the Advancement of Medical Instrumentation

#### *Safe Use of Medical Equipment Workshop*

The Workshop will present concentrated, practical information on how to use medical equipment safely. Attendees should return to their hospitals capable of inspecting their facilities, effecting corrections where necessary and training others on safe practices.

Physicians, nurses, administrators and hospital engineers are invited, as well as other interested hospital personnel.

The tuition fee includes training materials, notes, pertinent articles and lunch; \$45 for members and \$60 for non-members.

Erich E. Brueschke, M.D., Director, Medical Engineering Center, IIT Research Institute (Workshop Chairman)

Jerome M. Silver, M.D., Dir. of Surgical Education, Louis A. Weiss Memorial Hospital

Richard A. Carleton, M.D., Dir. of Cardio-Respiratory Diseases, Rush-Presbyterian-St. Luke's Medical Center

Jeb Boswell, M.D., Dir. of ECG Laboratory, University of Illinois Research Hospital

Michael M. Kaye, M.D., Scientific Dir., Heart Assist Devices Test and Evaluation Facility, IIT Research Institute

Sidney J. Blatt, M.D., Scientific Coord., Heart Assist Devices Test and Evaluation Facility, IIT Research Institute

Morton E. Goldberg, M.S.E.E., Asst. Dir. of Electronics Research, IIT Research Institute

Thomas H. Burdick, B.S.E.E., Medical Electronics Engineer, Travenol Labs., Inc.

Michael J. Miller, LL.B., Exec. Dir., AAMI

IIT Research Institute, 10 W. 35th St., Chicago/8:30-6:00



**June 11—Illinois State Psychiatric Institute  
& Institute for Juvenile Research**  
*Family Therapy Seminar*

*"New Directions in Family Therapy"*

Andrew Ferber, M.D., Director, Family Studies Section,  
Bronx (N.Y.) State Hospital, Albert Einstein College  
of Medicine

Auditorium, 1601 W. Taylor St., Chicago/  
1:30 p.m.

**June 15—Illinois State Psychiatric Institute  
& Institute for Juvenile Research**  
*New Perspectives Seminar*

*"An Interview with David Ben Gurion"*

Jack Weinberg, M.D., Clinical Director, I.S.P.I., Pro-  
fessor of Psychiatry, Abraham Lincoln College of  
Medicine

Auditorium, 1601 W. Taylor St., Chicago/  
2:30 p.m.

**June 16—The National Foundation March of  
Dimes—Metropolitan Chicago Chapter**  
Morning Session

*"Scope of Genetics in Medicine"*

Ronald G. Davidson, M.D.: Professor of Pediatrics,  
New York State University School of Medicine at Buf-  
falo, Division of Human Genetics, Children's Hospital,  
Buffalo, New York.

*"Practical Applications of Cytogenetics"*

Arthur Bloom, M.D.: Associate Professor of Medical  
Genetics, University of Michigan School of Medicine,  
Ann Arbor, Michigan.

*"Inborn Errors of Metabolism—Principles and  
Application"*

Leonard Pinsky, M.D.: Assistant Professor of Pediatrics,  
McGill University, Lady Davis Institute for Medical  
Research of the Jewish General Hospital, Montreal,  
Canada.

*"Screening for Genetic Defects"*

Harvey Levy, M.D.: Assistant Professor of Neurology,  
Harvard University, Cambridge, Massachusetts.

Afternoon Session

*"Genetic Counseling"*

David Rimoin, M.D.: Associate Professor Department  
of Pediatrics, UCLA Medical School, Los Angeles,  
California.

*"Prenatal Detection of Genetic Defects"*

Henry L. Nadler, M.D.: Given Research Professor,  
Chief of Staff, The Childrens Memorial Hospital,  
Chairman, Department of Pediatrics, Northwestern  
University Medical School, Chicago, Illinois.

*"Treatment of Genetic Defects"*

R. Rodney Howell, M.D.: Associate Professor of De-  
partment of Pediatrics, The Johns Hopkins School of  
Medicine, Baltimore, Maryland.

*"Community Resources"*

Murray Feingold, M.D.: Associate Professor of Pedi-  
atrics, Director, Center for Genetic Counseling and  
Birth Defect Evaluation, New England Medical Cen-  
ter Hospital, Boston, Massachusetts.

*"Discussion and Summation"*

Ian Porter, M.D.: Chairman, Department of Pediatrics,  
Albany Medical School, Albany, New York.

The Academy of General Practice has approved this  
program for 8 elective hours of credit. The American  
Dietetic Association has approved this program for 6 hours  
of continuing education credit.

The tuition fee is \$20 for physicians and paramedical  
personnel, and \$10 for interns and residents. A pre-  
registration form to insure admission is available from  
the Chapter office, 173 W. Madison Street, Chicago, 60602.  
Check should be made payable to Symposium on Genetic  
Counseling.

Sheraton-Chicago Hotel, 505 N. Michigan Ave.,  
Chicago

**June 20-24—American Medical Association**  
*120th Annual Convention*

Scientific program and exhibits and House of Dele-  
gates meeting will take place, with each of the 23  
major scientific sessions conducting scientific programs.

See AMA publications for details.

Atlantic City

**June 28-July 9—Central States Institute of  
Addiction**

*"Seminar on Addictions"—Sociology 390*

"Classification of Drugs-Use and Abuse"

Charles Schuster, Ph.D.

"Some Socio-Medical Questions" and "Medical Treat-  
ment of Drug Abuse"

Joseph Skom, M.D.

"Theory of Group Dynamics"

Michael Diamond, Ph.D.

"Psychology of Despair and Some Alternatives" and  
"Communication and Practice of Group Dynamics"

Richard P. Issel, Ph.D.

"Rehabilitation of the Addict-Abuser"

Joseph A. Bou-Sliman

"The Role of Federal Law Enforcement"

Lawrence Slotnik, R.Ph.

"State Law and Procedures: Civil and Criminal"

Roger Nauert, M.A., LL.B.

"Sociology of Drug Dependence"

Charles Suchar, M.A., Ph.D. candidate

"The Drug Traffic"

Charles Siragusa

"Drug Abuse and the Educator"

J. Joseph Levin, Ed.D.

The registration fee is \$25 and applicable to the  
\$200 tuition fee.

DePaul University, 2323 N. Seminary Place,  
Chicago

**July 11-12—Institute for Sex Research, In-  
diana University**

*Summer Program in Human Sexuality*

Lecture courses with special reference to the medical  
aspects of human sexuality, workshops in sex educa-  
tion and counseling, and small group discussions.

Tuition fee of \$25 includes housing.

Registration ends May 30.

Institute for Sex Research, Indiana Univer-  
sity, Bloomington, Ind.

(Save for reference)

# The terminally ill patient

(Continued from page 505)

compassion for him. The assistance of the minister in caring for both the patient and the family becomes a necessity when the patient suffers with a terminal illness.

Although my father was a Presbyterian minister and I have been active in my church most of my life, I feel inadequate to discuss ecumenical problems with my patients. Still, I realize that these areas are most important, especially for the fearful patient. I understand that not all clergymen "minister" to parishioners but that some are businessmen who look after the business part of the church and some are specialists in "social action." I would urge that only the pastor who understands and is sympathetic with people should minister to the sick.

The attitude of society in discussing the care of the seriously sick patient is clearly exemplified in the following true story. A patient had been in an auto accident eight years ago, and since then had been mentally unbalanced. Four years ago he developed a large cancer of his mouth, located in his cheek. His wife took him to see a nose and throat specialist who diagnosed his cancer and referred him to me. The patient was completely uncooperative, so it was impossible to treat him with the usual technique used in such cases. We finally took him to a hospital, and under an anesthetic, implanted the cancer with about 40 gold radon tubules  $\frac{1}{8}$  inch long, each containing a small amount of radon gas. This technique was successful and the tumor was completely destroyed. Unfortunately,

the man would not permit a physician to examine his mouth from that day until very recently. He lived at home with his wife, demanding constant watchful care.

The patient's wife has reported to me regularly during the past four years and about two months ago stated that, although the cheek seemed to be fine, he was having difficulty breathing. The patient would not come to see me or go to see any other doctor. Early in February, however, he became so ill that his wife had to take him to the hospital. An entirely new cancer, at the base of his tongue, was found, extending over the epiglottis and interfering with his breathing. He became much worse in the hospital and was soon semi-comatose. After about seven hours of this, the doctors were finally able to get permission to do a tracheotomy, which permitted him to breath freely. He soon recovered from the operation and became his usual mentally defective self.

In discussing his case with his wife over the phone, I pointed out that the possibility of complete recovery from his new tumor was very slight and that in time his growth would probably develop a foul and painful ulceration. I stated that in a way it was unfortunate he had regained consciousness after the operation. She said, "Every person has a right to live as long as God will let him and we must do all in our power to help." I can think of no more descriptive words to define the ethics society lays down for all of us in the consideration of the fatally sick patient. ◀

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## *Revised edition of booklet On anticoagulants published*

Updated information on the uses of anticoagulant drugs is contained in a completely revised and redesigned edition of the American Heart Association booklet, "A Guide to Anticoagulant Therapy," now available to physicians, hospitals and medical schools.

The publication furnishes guiding principles and practical recommendations in the uses of anticoagulants as aids in preventing thrombosis or embolism, including the latest findings on the clotting mechanism, where in that mechanism anticoagulants work and compatibilities and incompatibilities of other drugs with anticoagulants.

Copies of the revised booklet may be ordered through local Heart groups or the AHA National Office, 44 E. 23rd St., New York, N.Y. 10010.



Precision is a natural goal when you prescribe thyroid replacement therapy.

When you prescribe Proloid (thyroglobulin) you specify a precision blend of the two natural active hormones— $T_4$  and  $T_3$ —in their natural protein, *thyroglobulin*.

It's because Proloid is the natural thyroid hormone-globulin complex extracted and purified of unnecessary glandular debris.

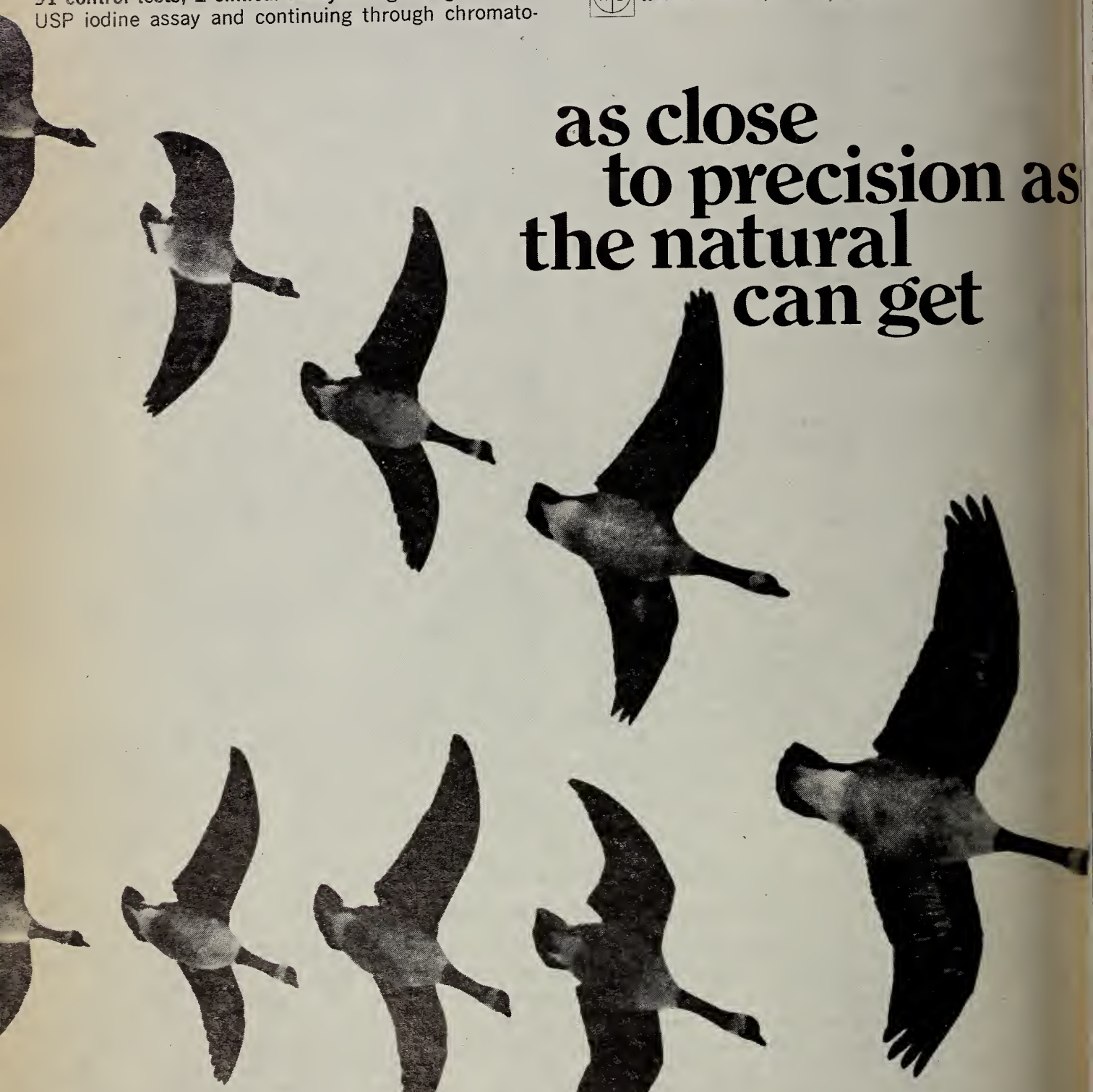
**91 control tests, 2 clinical assays:** Beginning with the USP iodine assay and continuing through chromato-

graphic analysis for  $T_4$  and  $T_3$  content and including testing in hypothyroid humans—Proloid is made as precise as the natural product can get, batch after batch.

**New 2 grain tablet:** Precision extends to dosage. With the introduction of a new 2 grain tablet, titration can be even more conveniently achieved with the full range of Proloid dosages:  $\frac{1}{4}$ ,  $\frac{1}{2}$ , 1,  $1\frac{1}{2}$ , the new 2, 3, and 5 grain tablets.



Warner-Chilcott, Morris Plains, N. J. 07950



as close  
to precision as  
the natural  
can get

**Proloid<sup>®</sup>**  
(thyroglobulin)  
the natural for precision

Proloid®(thyroglobulin)

**Description:** Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, sodium levothyroxine (T<sub>4</sub>) and sodium liothyronine (T<sub>3</sub>). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the sodium levothyroxine and sodium liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T<sub>4</sub> and T<sub>3</sub> in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

**Indications:** Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in non-emergency situations, in an attempt to reduce the size of such goiters.

**Contraindication:** Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

**Warnings:** Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid, and dosage should be started at a very low level and increased gradually.

**Precaution:** As with all thyroid preparations this drug will alter results of thyroid function tests.

**Adverse Reactions:** Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

**Dosage and Administration:** Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T<sub>3</sub> 131I resin sponge uptake, T<sub>3</sub> 131I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T<sub>4</sub> and T<sub>3</sub> is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

**Instructions for Use:** The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T<sub>4</sub> (sodium levothyroxine), T<sub>3</sub> (sodium liothyronine), or T<sub>4</sub>/T<sub>3</sub> (liotrix).

Dose of Proloid (thyroglobulin)	Dose of desiccated thyroid	Dose of T <sub>4</sub> (sodium levothyroxine)	Dose of T <sub>3</sub> (sodium liothyronine)	Dose of liotrix (T <sub>4</sub> /T <sub>3</sub> )
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

**Overdosage Symptoms:** Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

**How Supplied:** ¼ grain; ½ grain; scored 1 grain; 1½ grain; 3 grain; and scored 5 grain tablets, in bottles of 100 & 1000; and scored 2 grain tablets in bottles of 100.

Warner-Chilcott, Morris Plains, N. J. 07950

Rx Product Index

Achrostatin .....561  
Lederle Laboratories

Aventyl HCl .....470-472  
Eli Lilly and Company

Cordran Tape .....492  
Eli Lilly and Company

Dicarbosil .....562  
Arch Laboratories

Empirin w/Codeine .....464  
Burroughs Wellcome & Co.

Euthroid .....468-469  
Warner-Chilcott Laboratories

Halotestin .....532-533  
The Upjohn Company

Flagyl .....2nd Cover  
G. D. Searle & Co.

Hygroton .....3rd Cover  
Geigy Pharmaceutical Corp.

Kantrex .....479  
Bristol Laboratories

Librium .....480-481  
Noludar .....555, 559  
Valium .....Back Cover  
Roche Laboratories Div.  
Hoffmann-LaRoche, Inc.

Neo-Sporin Ointment .....484  
Burroughs Wellcome & Co.

Orenzyme/AVC .....475, 476  
National Drug Company

Phenaphen/Dimetapp .....537-538  
A. H. Robins Co. Inc.

Proloid .....550-551  
Warner-Chilcott Laboratories

Salutensin .....526-527  
Bristol Laboratories

Seconal Sodium .....528-529  
Eli Lilly and Company

Silain Gel .....482-483  
A. H. Robins Co., Inc.

Synthroid .....485-487  
Flint Laboratories Div.  
Travenol Laboratories, Inc.

Tepanil/Quinamm .....547-548  
National Drug Company



# Passage of the Comprehensive Drug Abuse Prevention & Control Act of 1970

## Calls for new responsibilities in handling controlled drugs . . .

Recent passage of the Comprehensive Drug Abuse Prevention and Control Act of 1970, of which the Controlled Substances Act (CSA) is a part, indicates that practitioners in Illinois, as well as throughout the United States, will have somewhat different responsibilities and will be involved in handling controlled drugs in a modified manner. The Controlled Substances Act became fully effective May 1, 1971.

The new act repeals over 50 previously existing pieces of law on the federal level. The Food, Drug and Cosmetic Act remains, however, and the FDA still has regulatory power over indicating prescribing requirements. Two primary thrusts exist under the CSA—regulatory and penal. Under the former, the intent is not to thwart legitimate use, but to prevent diversion of drugs to illicit use through traffickers. The penal section deals with felonious distribution of drugs. In addition to this federal act, 13 states have adopted the Uniform State Drug Abuse Control Act. As of this writing, this is pending in the Illinois legislature. It is a model bill tied into the Federal CSA.

All Illinois physicians should have received Department of Justice, Bureau of Narcotics and Dangerous Drugs (BNDD) form 224A. This should have been filled out immediately. Note line 6 in particular. Line 5 gives the new BNDD registration number (which replaces all IRS and FDA numbers after April 30) and page A1 of the form should be returned 45 days prior to the date in item 6. Page A2 should be retained for the physician's permanent records and page A3 should be sent in immediately to allow for temporary registration, which will allow the practitioner to write prescriptions for any drugs on the new schedules.

### Registration Information

On May 1, 1971, the registration requirements of Public Law 91-513, referred to as the "CSA" (Controlled Substances Act of 1970) became effective.

As of May 1, 1971, the Internal Revenue Service (IRS) and the Food and Drug Administration

(FDA) no longer issued registration authorizing a person or firm to handle Controlled Substances. **On May 1, 1971, registration with BNDD became effective.** Registration with BNDD does not necessarily discharge a firm's responsibility to register with FDA as a manufacturer or distributor of "DRUGS" as required by 21 CFR 132.

When completing the provisional registration application by individuals now registered with IRS and/or FDA, *NOTE* the BNDD registration number. **Beginning May 1, 1971, this number *MUST* be used on all correspondence to BNDD as well as on all orders, prescriptions and any other documents of transfer.**

### Restriction Classification

Item 10 of the registration form should be checked under box C and in the space immediately following insert "M.D." Only one box may be checked. **If a practitioner functions under two categories a separate form should be used for each. In addition, if the practitioner dispenses any drugs he must file form 225B.** Please call the Bureau for further information.

### Schedules

Former Classes of narcotics have been abolished. As of May 1, the term class A or B will no longer be recognized. Instead, five new schedules are being employed, under two of which are included both narcotic and non-narcotic substances.

Schedules are as follows:

#### SCHEDULE I—

Drugs in this schedule are those that have *no* accepted medical use in the United States. Some examples are Heroin, Marihuana, LSD, Peyote, Mescaline, Psilocybin, Tetrahydrocannabinols, Ketobemidone, Levomoamide, Racemoramide, Benzylmorphine, Dihydromorphine, Morphine methylsulfonate, Nicocodeine, Nicomorphine, and others.

#### SCHEDULE II—

Drugs in this schedule have a high abuse potential with severe psychic or physical dependence liability. Most of Schedule II Substances have been known in the past as **Class A Narcotic Drugs**. One non-narcotic substance is currently included in this schedule, the liquid injectable form of meth-

amphetamine. Some examples of Schedule II Narcotic Substances are: Opium, Morphine, Codeine, Dihydromorphinone (Dilaudid), Methadone (Dolophine), Pantopon, Meperidine (Demerol), Cocaine, Oxycodone (Percodan), Anileridine (Leritine), and Oxymorphone (Numorphan).

#### SCHEDULE III—

Drugs in this schedule have an abuse potential less than those in Schedules I & II, and include those drugs formerly known as **Class B Narcotics**, and in addition, non-narcotic drugs such as: Amphetamines, Glutethimide (Doriden), Phenmetrazine (Preludin), Methypylon (Noludar), Methylphenidate (Ritalin), Methamphetamines (Syndrox-Desoxyn-Methedrine), Chlorhexadol, Phencyclidine, Sulfondiethylmethane, Sulfonmethane, Nalorphine, and Barbiturates (except Phenobarbital, Methylphenobarbital and Barbital). Paregoric is now listed in this schedule.

#### SCHEDULE IV—

The drugs in this schedule have an abuse potential less than those listed in Schedule III and include drugs such as: Barbital, Phenobarbital, Methylphenobarbital, Chloral Betaine (Beta Chlor), Chloral Hydrate, Ethchlorvynol (Placidyl), Ethinamate (Valmid), Meproamate (Equanil, Miltown), Paraldehyde, Pentaerythritol Chloral (Petrichloral), and Methohexital.

#### SCHEDULE V—

The drugs in this schedule have an abuse potential less than those listed in Schedule IV, and consists of those preparations formerly known as Exempt Narcotics, with the exception of Paregoric (Camphorated Tincture of Opium). Paregoric is now listed as a Schedule III Controlled Substance.

**It is recommended that practitioners in Illinois who presently hold a valid license, and who presently may prescribe narcotics, check all six boxes (Schedules II, III, IV, and V) under Part II of the form. If certain boxes are not checked, the practitioner will not be able to prescribe drugs under that schedule.** Note that former Class A narcotics are under Schedule II, and former Class B narcotics are in Schedule III.



Part of the reason for the new schedules is to allow flexibility to control dangerous drugs with a high potential for abuse. Under this new act items can be shifted up or down in the schedule without an act of Congress. The schedules allow judgment of potential for abuse and legitimacy of use.

### **Order Forms**

New regulations exist for ordering controlled drugs for use by the physician. After April 30, 1971, the Internal Revenue Service will no longer issue order forms. Starting on May 1, 1971, BNDD began issuing forms. **A registrant desiring the new BNDD order forms after May 1, 1971, may obtain them by using the requisition form (IRS-679) which is located in the back of his current IRS Order Form Book.** To obtain the new BNDD order forms place the new BNDD number (which appears in Block #5 of the registration application form) in Section #8 of the IRS Requisition Form, sign and forward to BNDD, Registration Branch, P.O. Box 28083, Central Station, Washington, D.C. 20005.

### **No charge will be made for the Order Forms.**

Existing order forms (IRS Form 2513) in your possession will be valid until April 30, 1972, for transfer of Schedule I and II Controlled Substances. Registrants wishing to use the IRS Order Forms after April 30, 1971, must insert the new BNDD number on the order form in the block which contains the name, address, old IRS registration number, and class of registration.

**Note: If you choose to obtain and use the BNDD Order Forms immediately and still possess the IRS Order Forms, DO NOT DISCARD THE IRS FORMS. Draw a line through the unused forms and print "VOID" across the line. Keep these forms for at least two years from May 1, 1971.**

### **Prescriptions**

Prescriptions that are filled for Controlled Substances in Schedule II must be written in ink or indelible pencil and must be signed by the practitioner issuing such prescriptions.

No prescription for a Controlled Substance in Schedule II may be refilled and such prescriptions, as well as prescriptions for narcotic substances in Schedules III, IV, and V, must be kept on a separate file.

Prescriptions for Controlled Substances in Schedules III or IV may be issued either orally

or in writing and may be refilled if so authorized. Such prescriptions may not be filled or refilled more than six months after the date issued, or be refilled more than five times after the date issued. After five refills or after six months the practitioner may renew any such prescription. A renewal of any such prescription should be recorded on a new prescription blank and a new prescription number assigned to such prescription.

### **Records**

**Every person or firm who manufactures, distributes, or dispenses any Controlled Substance must keep complete and accurate records of all receiving and distribution transactions.** All such records shall be maintained for a period of two years. Researchers are also required to maintain adequate records pertaining to Controlled Substances.

Records pertaining to substances in Schedule II and narcotic substances in Schedules III, IV, and V must be kept separate. All records pertaining to Controlled Substances shall be made available for inspection and copying by officers of the United States authorized by the Attorney General.

On the effective date of this Act, Saturday, May 1, 1971, or as soon thereafter as any registrant first engages in business, and every two years thereafter, must make a complete inventory of all stocks of Controlled Substances on hand. This inventory record shall be kept for a period of two years.

### **"Hot Line" for inquiries**

Since not all practitioners will fit nicely into these basic definitions, some questions will arise. **The Department of Justice has established a special "hot line" phone in Chicago to answer inquiries. The number to call is (312) 353-1234.** The Department has indicated a certain degree of leniency in the initial application of the 1970 CSA. However, they will not tolerate persons willfully not complying with the law.

This exercise on the part of the government is intended to make more facile the control of illicit drug traffic. Any inconveniences have been regretted, according to spokesmen for the Bureau. Physicians should feel free to write or phone the department: Suite 1700, Engineering Bldg., 205 W. Wacker Drive, Chicago, 60606. ◀



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for the rest  
of the night**

Before prescribing, please consult complete product information, a summary of which follows:

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**CONTRAINDICATIONS:** Patients with known hypersensitivity to the drug.

**WARNINGS:** Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

**Physical and Psychological Dependence:** Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

**Usage in Pregnancy:** Weigh potential benefits in pregnancy, during lactation, or in women of child-bearing age against possible hazards to mother and child.

**PRECAUTIONS:** If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

**ADVERSE REACTIONS:** At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.



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## practice management

### *Good collections mean good public relations*

BY ROBERT P. REVENAUGH/PROFESSIONAL BUSINESS MANAGEMENT, INC.

An astute dentist will insist that a denture be paid for at the time it is inserted in the patient's mouth. Why? He has learned that his appliance will never be as comfortable as natural teeth and the patient will never psychologically accept this change until he has paid for it. Once the bill has been paid the transaction is forgotten. When a delinquent patient is finally prodded into paying or providing a plan for payment he will invariably make an appointment for more services.

An unpaid bill is an open sore. The patient who owes the doctor money will seldom come into the office except when absolutely necessary. After many years of experience as a professional management consultant working with doctors' business problems, among which are delinquent accounts, I notice a pattern in the delinquent patient's thinking. The first and second bill are rationalized away by the thought that he doesn't have the full amount. He starts questioning the size of the bill after the third or fourth bill. After the fourth or fifth month he starts questioning your integrity. After the sixth month he is telling his friends that you are a louse. Because of a poor collection procedure you may not only lose money but the patient as well. What is worse, that patient defames your character to other prospective patients.

A stock answer of doctors to this situation is "who needs that patient or his friends anyway?" This presupposes that a delinquent patient is a special character. Unfortunately, with the free extension of credit today any patient can be delinquent, including your best friend. For the most part the delinquent patient is not the one who is *unable* to pay. That patient with a gen-

uine hardship situation will invariably tell you of his plight and insist on some payment arrangement. Seldom is the delinquent patient *unwilling* to pay.

Most dishonest people are in jail or occasionally an immature patient may consider you personally responsible for a bad medical result. In the main, the delinquent patient is one of the 20% of our population who is living beyond his means. He would like to pay you but just doesn't have the cash right now. While one might think that lower income people are the most likely to live beyond their means actually such delinquents are most often found in the upper middle class. Without being able to detect who delinquent patients might be, it is best to follow a collection system that is applicable to all patients—treat them equally.

Recovering a high percentage of your services rendered is the desired goal. Gimmicks seldom achieve results. On the contrary, a high collection ratio tells me that many facets of your practice are running smoothly. It tells me that patients are accepting your fees, that they are both reasonable and that you are probably quoting larger fees in advance of treatment. It indicates that patients are satisfied with your medical services. A high collection ratio also reveals that you have a proper credit philosophy which you have communicated to your aide to implement; that you expect to be paid by patients, and if they are unable to pay, you expect patients to tell you so and indicate how and when they will pay. A high collection rate indicates that your aide at the front desk is apprised of the office visit charge before the patient leaves the office

and she makes a positive suggestion to the patient to pay immediately. Your aide bills the patients properly, regularly, and promptly at the end of each month; she is up to date on her insurance work. A good collection percentage also shows that you are using an effective and routine method of following up delinquent accounts.

I have described good collections as good public relations. Good collections also measure the effectiveness of several office systems. In addition,

good collections can be profitable to you. I estimate that in the average medical office you will collect only 92% of the fees you render. In a well managed practice the collection ratio will be 97%. This additional 5% may not seem much to you, but if the average doctor saved and invested this difference over thirty years he would have \$140,000 more available to him, even after taxes.

---

## *Overeating -- A serious problem of aging*

Overeating is one of the serious problems of aging, according to Veterans Administration psychiatrist Dr. Kurt Wolff. He reported recently that 50% of the men over 65, and 47% of the women of that age group, are more than 10% above their optimal weight.

Dr. Wolff's observations are based on a large body of VA research on aging and care of geriatric patients. Almost 16% of the patient population in VA's 166 hospitals are over 65.

To help avoid or postpone many of the physical illnesses associated with old age, Dr. Wolff recommends that old people reduce their caloric intake, especially with regard to fat, and take more proteins.

Dr. Wolff is director of professional education and research at the Coatesville, Pa., VA Hospital where he has cared for geriatric patients for the past 16 years. In his recent book, *THE EMOTIONAL REHABILITATION OF THE GERIATRIC PATIENT*, Dr. Wolff reviews concepts and treatment methods for the elderly, both inside and outside hospitals, and describes productive ways of prevention, treatment and rehabilitation of the aged.

Among his diet recommendations are these: "The older person can help his own diet by mixing dry skim milk or dry yeast into his foods. . . . Milk is probably the best food for later life. . . . Among the plant proteins, the best is from soy beans.

"Brewer's yeast is one of the richest natural sources of both protein and water-soluble vitamins. It should be taken before meals by those who tend to become overweight. It can be used to lessen the need for insulin by diabetics and help prevent constipation, but it may cause trouble for those afflicted with gout."

The VA physician also points out specific psychological characteristics of the elderly—the fear of death and dying, and the distorted image and the lack of a purpose in life that many have.

Dr. Wolff reports that the percentage of the United States population over age 65 has doubled in this century, from 4.1% in 1900, to 9.5% in 1968 (from 3 million to 19 million).

Women now outlive men with a life expectancy at birth of 73.8 years against 66.7 years for males.



# EKG of the month. . . . .

(Continued from page 497)

## ANSWERS

1. *b, d, and e.* The frontal plane QRS axis is  $+120^\circ$ , right axis deviation. This finding coupled with an R complex in  $V_1$  indicates right ventricular hypertrophy, indeed a R wave in  $V_1$  greater than 12 mm. without an S component implies right ventricular pressure overload. The bi-phasic P wave in  $V_1$  with a negative component greater than 1.0 mm<sup>2</sup> in magnitude implies left atrial enlargement.
2. *c and e.* The physical findings described are classic for tight mitral stenosis and pulmonary hypertension. Cardiac catheterization demonstrated a pulmonary artery pressure of 110 mm. Hg. systolic, and a Mitral valve diastolic gradient of 25 mm. Hg. The calculated mitral valve area was less than 0.6 cm.<sup>2</sup> These findings were confirmed during surgery, a successful mitral commissurotomy.

---

## Viewbox

(Continued from page 502)

**DIAGNOSIS:** *Diffuse Systemic Sclerosis (scleroderma).* Scleroderma is a collagen disease characterized by atrophy and sclerosis of many organ systems. Of major importance to the clinician is the involvement of the skin, GI tract, musculoskeletal system, heart and lungs.

The radiographic changes are as follows: In the lungs, the picture is one of diffuse interstitial fibrosis manifested at different stages of the disease by variations of a honeycomb pattern. The lower lung fields are usually involved. However, the upper lung fields may become progressively involved as the disease progresses. Small peripheral cysts may be noted and spontaneous pneumothorax may occur. Positive roentgenologic changes in the lungs occur in about 25% of the cases and pulmonary symptoms in only about 16%; however, pulmonary function studies usually reveal a considerable number of the cases with abnormality not manifested by X-ray (Fig. 1).

The GI tract will show its most characteristic

findings in esophageal dilatation and aperistalsis. The esophagus is involved in about 50% of the cases. The fluoroscopic study is most revealing in a supine position, as in the upright position gravity will mask the inability of the esophagus to propel a bolus (Fig. 2). Aperistalsis and abnormal motility of the stomach and small bowel are frequently noted. The appearance of unusually wide sacculations of the colon on the anti-mesenteric side are fairly characteristic of scleroderma.

The musculo-skeletal system showed changes chiefly associated with Raynauds' phenomenon. This will be evident by absorption of the distal phalanges (Fig. 3) particularly when associated with calcinosis of the terminal pulp. Calcinosis may be seen in other sites, particularly over pressure areas such as the elbows and ischial tuberosities. The resorption of the distal end of the clavicle is noted occasionally in scleroderma. Arthritis of the interphalangeal joints is not uncommon. The teeth may even be affected by evidence of widening of the periodontal space.

---

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**CONTRAINDICATIONS:** Patients with known hypersensitivity to the drug.

**WARNINGS:** Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

**Physical and Psychological Dependence:** Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with

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## the presidents page

(Continued from page 474)

It should be noticed that 38 state medical societies have made definite efforts to initiate continuing education for their members. Three have required a definite number of hours of study for membership, as does the Academy of General Practice. Two state Legislatures are considering compulsory relicensure every few years. Some hospitals are requiring credit in continuing education for staff membership.

This statewide effort of ISMS is designed to produce many new programs, encourage experiments in new learning techniques, prevent duplications and provide the right program at the right time and in the right place.

*J. Ernest Breed M.D.*

## Surgical Grand Rounds

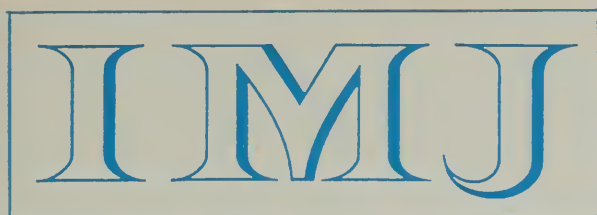
(Continued from page 501)

**Dr. Putong:** The lymph nodes were found to be free of carcinoma.

**Dr. Beal:** In that case, the prognosis is better. Survival correlates best with the presence or absence of involved lymph nodes. ◀

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Cumulative Index .....	622
------------------------	-----

clinical  
articles

Dissecting aneurysm of superior mesenteric artery <i>Bak Moo Lee, M.D. and Ben H. Neiman, M.D.</i> .....	589
Clinical experience with a new laxative in children <i>Lester A. Nathan, M.D.</i> .....	598
Disseminated Chlamydial infection <i>Wayne M. Kassel, M.D., George C. Sutton, M.D., Clarence MacPharland, M.D., and C. Laurence Etheridge, M.D.</i> .....	600

surgical  
grand rounds

Vesicoureteral reflux .....	594
-----------------------------	-----

medical  
progress

Drug therapy in alcoholism <i>Verdad Oge, M.D.</i> .....	606
---	-----

special  
article

Medical Gobbledygook and Writer's Gookledygobb <i>Lois DeBakey, M.D.</i> .....	614
---	-----

features

blue shield report .....	565
obituaries .....	577
the presidents page .....	582
the viewbox .....	593
ekg of the month .....	605
the doctors library .....	611
membership forum .....	613
new pharmaceutical specialties .....	618
editorials .....	620
clinics for handicapped children .....	621
practice management .....	631
socio-economic news .....	632
imaa report .....	636
what goes on .....	643

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# BLUE SHIELD REPORT



## FOR *Illinois Physicians*

### SUMMARY OF ANNUAL REPORT, 1970

Most of the problems that faced Blue Shield in 1969 were with us in 1970. We noted, however, an increased awareness on the part of legislators and the general public of the immensely complex problems facing the health care field.

This annual report discusses many of these problems and describes Blue Shield innovations which can contribute significantly to their solution. At the same time, Blue Shield performance in some of the more traditional areas is covered. For example, in 1970 the dollar volume of claims provided on behalf of subscribers amounted to \$52,622,016, an increase over 1969 of almost 25 percent, while membership was up by 109,244.

The increased usage of Blue Shield services and costs which occurred in 1970 was greater than we had anticipated. As a result, we had to use part of our reserve funds—\$3.6 million—to meet the needs of our members.

Our job is clearly defined. In every way possible—in the day-to-day servicing of claims, in new techniques designed to speed operation and increase efficiency, in better methods of working with physicians, in improved relations with our members and the community at large, in experiments with new benefit programs and new working relationships with physicians—we are doing and will con-

tinue to do everything possible to improve our operations.

Examples of our efforts include an experiment in prepaid group practice and expansion into the prepaid dental field through our affiliate, Fort Dearborn Life Insurance Company. We are deeply concerned with the social problems of health care—its costs, its adequacy, its meaning. It is because of this that we work both with medical societies representing physicians and community groups representing the public.

Is there more we can do to be of help to our members—to physicians—to the community? Only through open dialogue—only through the frank discussion of mutual problems and consideration of suggestions offered by all—can we find new solutions and better answers.

Robert M. Redinger  
Executive Vice President

### Ambulatory and Progressive Care Programs Developed

In 1970, a large share of Blue Shield members were eligible for ambulatory care benefit programs designed to treat individuals out of a hospital bed. Under these programs, Blue Shield subscribers receive benefits for out-patient surgery, medical emergency services and diagnostic tests provided in the hospital's out-patient or emergency room department.

The number of our Pre-Admission Testing (PAT) programs—designed to save a day of hospital care by providing pre-surgical tests on an out-patient basis—is increasing. Some 17 hospitals adopted PAT during 1970 to bring the total of hospitals participating in the program to 43 by year's end.

Following hospitalization, Blue Shield benefits, on many certificates, are available for physician-care in the home or in extended care facilities for patients not requiring the full facilities or services of the hospital.

### PROFESSIONAL RELATIONS ACTIVITIES

Blue Shield's Professional Relations Department field representatives traveled throughout Illinois in 1970, providing information to physicians in their offices, at hospital staff meetings, at medical conventions and as speakers at medical society meetings. The mutual understanding gained through these meetings simplifies procedures and eliminates delays in payments of bills for patient care.

In 1970, more than 5,000 medical assistants in Illinois were given special training in Blue Shield administrative, claims and payment procedures. Through special seminars staffed by members of Blue Shield's Professional Relations Department, medical assistants employed in clinics and physicians' offices were given careful training and kept fully informed as new benefits were added or procedures revised.



## ASK BLUE SHIELD

### • • • ABOUT MEDICARE

## Filing For Medicare Benefits . . . What You Should Know

How a physician files for Medicare benefits depends on whether or not he accepts assignment and whether the patient is a Public Aid recipient. In all cases, the SSA 1490 "Request for Medical Payment" form should be used.

Accepting assignment means that the patient and the physician agree to have Medicare make payment directly to the physician and the physician agrees to accept the reasonable charge as payment in full.

Each year a \$50.00 Part B deductible must be met. If any portion of the deductible is outstanding, that amount will be deducted from the reasonable charge. Medicare will then pay the physician 80 per cent of the reasonable charge or remaining balance. The physician cannot collect from the patient more than the 20 per cent coinsurance and any charges applied toward the deductible. However, he may bill the patient for any services which are not eligible for Part B benefits.

For Public Aid recipients the physician must accept assignment. The SSA 1490 should be prepared in triplicate. One copy is sent to the Medicare carrier, one copy is sent to the Public Aid office, and one copy is kept in the physician's files. When making payment, the Medicare carrier sends a copy of the Explanation of Medicare Benefits (EOMB) to the Illinois Department of Public Aid in Springfield for additional processing.

The patient's signature must appear on every SSA 1490 except in the following circumstances:

1. When the patient is a Public Aid recipient, the physician should write "Public Aid" in the signature box. The patient need not sign.
2. When the patient is unable to sign, a relative may sign for him, indicating his relationship to the patient and explaining why the patient could not sign.
3. When the patient is deceased and the physician agrees to accept assignment, the physician may sign for the patient and indicate that the patient is deceased.

A physician who is treating a patient over an extended period and who agrees to accept assignment may obtain the patient's consent to assignment of unpaid bills for an anticipated period of treatment by having the patient sign a statement such as: "I request that payment under the medical insurance program be made directly to Dr. \_\_\_\_\_ on any unpaid bills for the services furnished to me by that physician during the period \_\_\_\_\_ to

\_\_\_\_\_." However, the period should extend no longer than the close of the calendar year. The statement should be attached to the original claim and submitted in the usual manner. On subsequent claims, the physician should indicate "This is a continuation of a course of treatment for which the patient's assignment was previously obtained" in the patient's signature box.

The physician's signature is necessary only on those claim for which assignment is accepted.

In cases where the physician does not accept assignment or when the patient has paid the bill, Medicare will make payment directly to the patient. In these cases, the physician should supply the patient with an itemized statement, or he may file for the patient by submitting an SSA 1490 and indicating that he will not accept assignment.

## Verification Of Hospital Visits

Many Medicare Part B claims for hospital visits by physicians have been delayed or disallowed. Concerning hospital visits, the Social Security Administration's Part B Intermediary Manual states:

"In the case of hospital visits by physicians, it may be presumed, in the absence of evidence to the contrary, that visits billed for were made. . . . Verification of each claim need not be undertaken. . . . However, spotchecks of available records with respect to a particular physician should be made when the carrier's records show questionable patterns of utilization. Confirmation should also be obtained where the medical facts do not support the frequency of physician's visits or in the cases of beneficiary complaints.

"If there is a question of whether the visit has been made, the burden of proof is on the physician to substantiate the occurrence of a hospital visit. Verification should be made primarily on the physician's own entry in the patient's record at the hospital. Entries in the hospital record made by other persons could also be used to substantiate a hospital visit. For example, an entry in the nurses' notes indicating that the physician saw the patient on a given day would be acceptable documentation. . . . The fact that the hospital's policy requires daily physician visits would not be conclusive evidence if, in the individual case, the facts did not support a finding that daily hospital visits were actually made."

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**Indications** *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

**Contraindications** Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

**Precautions** Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

**Adverse reactions** Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

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## Obituaries

**Siegfried Haber**, Chicago, died Feb. 7, at the age of 73.

**\*Earl Stephenson**, Arlington Heights, died Jan. 1, at the age of 66.

**Glenn G. Haight**, East Alton, died March 27.

**Richard B. Ritcher**, LaPorte, past president of the Chicago Neurological Society, died April 7, at the age of 69.

**\*Curtis B. Bowman**, 75, retired Chicago surgeon, died April 7. He had been residing in LaVerne, Calif.

**\*Henry Jacobs**, Spring Valley, died April 9, at the age of 59. He was past vice-president of the medical staff at St. Margaret's Hospital.

**Michael Chichkan**, Lake Geneva, Wisc., former physician with the Chicago Police Dept., died April 9, at the age of 71.

**\*Edward A. Roling**, Lake Villa, died April 19, at the age of 73.

**Earl R. Hahn**, Chicago, died April 14, at the age of 75.

**Howard M. Goodsmith**, Northlake, died April 15, at the age of 80.

**\*Roman C. Dalka**, Chicago, died April 20.

**\*Irvin W. Kross**, Leland, died April 20.

**\*Alfred A. Rosenberg**, Chicago, died April 23, at the age of 84. He practiced medicine in the Chicago area for 50 years.

**\*\*O. B. Williams**, Chicago, a physician for 54 years, died April 25, at the age of 77.

**Glen E. Ehrler**, Downers Grove, past president of the DuPage County Medical Society died April 26, at the age of 69.

**\*\*Albert G. Peters**, Gibson, died April 28, at the age of 77.

**Francis Werner**, Chicago, died April 28.

**Leonard B. E. Oliver**, Woodstock, a retired physician and surgeon, died April 30, at the age of 80.

**Rudolph Weil**, Oakridge, died May 3.

**Clarence Cohn**, Winnetka, head of the Nutritional Science Department at Michael Reese Hospital, died May 3, at the age of 60.

**\*\*Theodore K. Lawless**, Chicago, a prominent dermatologist and philanthropist, died May 2, at the age of 78.

\*Denotes member of ISMS.

\*\*Denotes membership in ISMS and Fifty Year Club.





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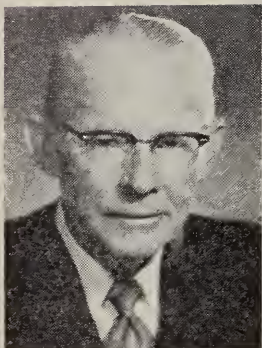
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## the presidents page

### What is ISMS doing?

Physicians often ask what is happening at the Illinois State Medical Society. In what activities are we engaged? What actions are being taken on behalf of the members?

This is a very legitimate concern, one which I have shared in the past.

Needless to say, your ISMS is, as common jargon goes, "With it!" The Society, through its board, committees, councils, and task forces, is facing up to many problems and concerns facing medicine today, in scientific, socio-economic, and medical-legal aspects.

ISMS representatives "invested" over 120 hours conducting or addressing 25 different meetings involving nearly 1,000 people during the month of April alone!

Let me review some of the more recent activity. This somewhat dry, but factual item, will give an idea of the degree and intensity of activity.

- April 1—Illinois Nutrition Committee (5 people, 3 hours)
- April 3—Council on Mental Health and Addiction (16 people, 2½ hours)
- April 4—Public Affairs Committee (21 people, 2 hours)
- April 6—ISMS Foundation presentation to Adams County Medical Society in Quincy (44 people, 2½ hours)
- April 7—Ear, Nose, Throat Committee (8 people, 1 hour)
- April 7—ISMS Foundation presentation at the 8th District meeting in Mattoon (17 people, 3 hours)
- April 7—ISMS Foundation presentation to the DuPage County Medical Society (16 people, 2½ hours)

- April 8—ISMS Foundation presentation to a joint meeting of Warren, Mercer and Henderson Counties in Monmouth (17 people, 2½ hours)
  - April 13—ISMS Foundation presentation to the 3rd District and the CMS Council (62 people, 3 hours)
  - April 13—ISMS Foundation presentation to the Rock Island County Medical Society (62 people, 2½ hours)
  - April 14—Health Care Financing Committee (10 people, 4 hours)
  - April 14—Task Force on Physician Shortage and Services to Medically Deprived Areas (17 people, 4 hours)
  - April 15—Committee on Drugs and Therapeutics (7 people, 3½ hours)
  - April 16—Council on Education and Manpower (9 people, 3½ hours)
  - April 17—Council on Legislation and Public Affairs (17 people 3½ hours)
  - April 18—ISMS Foundation presentation to the Illinois Academy of General Practice (152 people, 3½ hours)
  - April 18—ISMS Foundation presentation to the 10th District in Bellevue (28 people, 3 hours)
  - April 20—ISMS Foundation presentation to the Southern Cook County Branch of CMS (32 people, 2½ hours)
  - April 21—Editorial Board (10 people, 2 hours)
  - April 23-25—IMAA Annual Meeting in Champaign (275 people, 3 days)
  - April 24—ISMS Foundation presentation to the 6th District in Jacksonville (15 people, 3 hours)
- (Continued on page 640)*



I M J  
*Illinois Medical Journal*

# Dissecting aneurysm of superior mesenteric artery

BY BAK MOO LEE, M.D., AND BEN H. NEIMAN, M.D.

Dissecting aneurysm of aorta has been reported with a relatively high incidence in autopsy cases; from four per cent to 22%. However, dissecting aneurysm of peripheral arteries, not associated with aortic dissection, is uncommon, though reported in cerebral artery, vertebral artery, thyroid artery, basilar artery, carotid artery, pulmonay artery, coronary artery, retinal artery, celiac artery, renal artery, splenic artery, hepatic artery, iliac artery and superior mesenteric artery.<sup>3,4,9-19</sup> Dissecting aneurysm of superior mesenteric artery is exceptionally rare, with one case reported by Bauersfeld<sup>2</sup> and four cases by Foord and Lewis.<sup>3</sup>

## Case Report:

A 62-year-old, white male was admitted on July 12, to MacNeal Memorial Hospital through the emergency room. Physical examination re-

vealed no obtainable blood pressure, weak and thready pulse, marked pallor, slightly distended abdomen, no blood in stool by rectal examina-

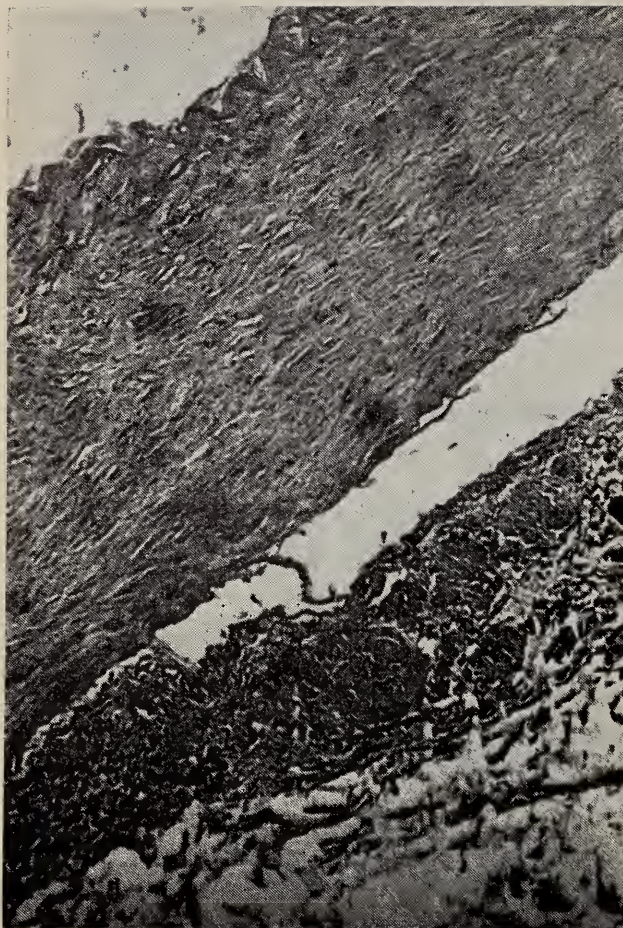


BAK MOO LEE, M.D., (right) is an associate pathologist at MacNeal Memorial Hospital, in Berwyn, and a Diplomate of The American Board of Pathology. He received his M.D. degree from Kyung-Pook National University, School of Medicine, in Korea.

BEN H. NEIMAN, M.D., (left) is pathologist-in-chief, and director of Laboratories at MacNeal Memorial Hospital in Berwyn, and professor of pathology at Chicago Medical School. Dr. Neiman received his M.D. degree from Rush Medical College, and is a Diplomate of The American Board of Pathology.







**Fig. 1. The section of superior mesenteric artery shows V-shaped split between media and external elastic lamina due to dissection aneurysm. Blood has dropped out in handling (hematoxylin-eosin stain).**

tion and no tenderness in abdomen. Additional significant medical history obtained revealed partial gastrectomy for G-I bleeding several years ago and abdominal discomfort for two days prior to admission. Hemoglobin was 9.7 gm.%, Hct. was 30% and WBC 14,200 with 72% polys. Whole blood was given with the result of a mild improvement of vital signs, but he complained of sharp abdominal pain, went into shock and expired within 24 hours after arrival in the emergency room.

### **Autopsy Findings**

The most striking gross alteration was approximately 2500 c.c. of partly clotted blood in the peritoneal cavity, most of it accumulated in the root of the mesentery with some extension of hemorrhage to the retroperitoneal adipose tissue. The main trunk of the superior mesenteric artery presented the evidence of lamination and striation extending to the branches showing a

definite double-barreled channel with marked separation of vessel wall and the clotted blood between separated layers. There are extensive hemorrhages in the mesentery, especially the perivascular area, with evidence of rupture and laceration of the blood vessel. The aorta showed minimal degree of arteriosclerosis without any evidence of dissection. The area of previous partial gastrectomy showed no significant changes. The external surface of small intestine showed congestion and focal hemorrhage, but the mucosa showed no significant changes.

Microscopically, the section of the superior mesenteric artery taken at main trunk (Fig. 1) and primary branches showed complete separation of the vessel wall between the media and external elastic lamina but any significant alterative changes such as cystic medial degeneration were not identified by hematoxylineosin or Verhoeff Van Gieson stain. The section of small intestine showed focal hemorrhage of the serosa but the mucosa and muscle layer showed a well preserved appearance. The sections of other organs showed no significant changes except mild arteriosclerosis and benign nephrosclerosis.

### **Discussion**

The common pathological type of aneurysm involving the superior mesenteric artery was mycotic (63%),<sup>20</sup> which is commonly associated bacterial endocarditis. Some of the cases were diagnosed preoperatively and treated with a good result.<sup>20-28</sup> As only six cases are available for discussion of dissecting aneurysm involving the superior mesenteric artery, it is not conclusive to discuss etiology, incidence, symptoms, signs and pathological findings. However, as seen in Table 1, there are some common findings among these six cases.

Dissecting aneurysm of the aorta has evidence of an increasing incidence related to an aging population. Cases are found to be over 55 years of age. However, there is a reported case of dissecting aneurysm involving the middle cerebral artery at age 15.<sup>15</sup> There is no significant difference of incidence related to sex,<sup>2</sup> but it has been reported that the dissecting aneurysm of the coronary artery<sup>10</sup> and aorta<sup>1</sup> were associated with pregnancy and labor. All the six patients studied had relatively acute onsets of abdominal pain or discomfort, followed by symptoms of intestinal obstruction when the occlusion of an artery occurred and shock when the artery ruptured. There also may be severe dyspnea<sup>2</sup> as seen by the dissecting aneurysm of the aorta and other



peripheral arteries, abdominal distention, nausea, vomiting and cyanosis. It takes from three to 21 days, which is relatively short, for the onset of symptoms to death. In regards to a history of hypertension, it has been reported that there is some relation between the dissecting aneurysm and hypertension<sup>1,2</sup> but these six cases showed no significant correlation.

Some investigators described significant arteriosclerotic changes of the aorta in the case of dissecting aneurysm. Although the six cases had mild to severe degrees of generalized arteriosclerosis, it is not unusual to see those changes in aging people and it is not conclusive to state any relationship between the dissecting aneurysm of the superior mesenteric artery and generalized arteriosclerosis. Regarding pathological findings

of superior mesenteric artery and intestine, Bauersfeld<sup>2</sup> pointed out that the dissection may take one of three following courses: (1) Progressive involvement of vessel and rupture back into lumen; (2) Progress a variable distance and cease; and (3) Rupture through the adventitia. This latter event is the most common result and occurs in 80-90% of the cases of dissecting aneurysm.

Dissecting aneurysm of peripheral artery has a different prominence of course. Commonly, the intramural hemorrhage or hematoma was formed, resulting in a narrowing or occluded lumen associated with the infarct of related organ. The next common course is the development of the intimal tear associated with the formation of intraluminal thrombosis, resulting in the infarct

Table 1

Cases reported by	Foord and Lewis				Bauersfeld	Author
Age	58	75	73	55	87	52
Sex	M	F	F	M	F	M
Symptoms and Signs	Severe sub-sternal pain for 5 days prior to death	Sudden onset of intestinal obstruction, cause unknown, with vomiting, abdominal pain and distention	Marked splenomegaly; clinically, myeloid hyperplasia	Severe dyspnea, cyanosis, acute onset of abdominal pain, distention, and vomiting	Mild epigastric pain, nausea and vomiting	Mild abdominal pain for 2 days, sudden development of shock with the episode of sharp abdominal pain
Duration of course	5 days	7 days	Unknown	17 days	21 days	3 days
History of hypertension	Hypertensive for nine years	No	No	Hypertensive for unknown period	No	No
Arteriosclerosis of aorta	Moderate	Moderate	Moderate	Severe	Moderate	Mild
Intimal tear	No	Yes	No	No	Yes	No
Thrombosis of artery	No	No	No	No	Yes	No
Infarction of intestine	Yes	Yes	No	Yes	Yes	No
Lesion of split	Between media and external elastic lamina	Between media and external elastic lamina	Between media and external elastic lamina	Between media and external elastic lamina	Between media and external elastic lamina	Between media and external elastic lamina
Evidence of medial degenerative change	No	Yes	No	No	No	No
Other significant findings	Dissecting aneurysm of right renal artery		Generalized tuberculosis		X-ray showed the evidence of partial bowel obstruction	Rupture through adventitia, resulting peritoneal hemorrhage



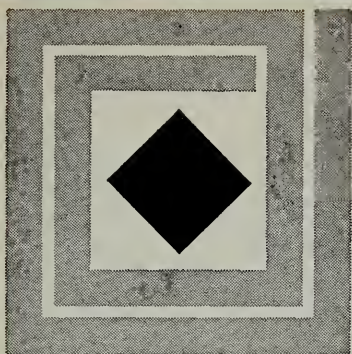
of related organ. The rupture through the adventitia, resulting in sudden death due to hemorrhage, is rare but seen in this reporting case as well as a previous reported case of common hepatic artery.<sup>19</sup> Microscopically, all previous literature has noted the evidence of medical degenerative changes by using many different special stains and techniques. Some of them have reported the positive findings as there is a significant correlation between the dissecting aneurysm and so called ideopathic cystic medial degeneration, and some of them gave negative findings. In cases of the superior mesenteric artery, there is one case which has the evidence of medical degenerative changes among six cases, so it is very difficult to evaluate the relationship between the dissecting aneurysm of the superior mesenteric artery and medial degenerative changes. The lesion of split was found between the media and external elastic lamina in all six cases involving superior mesenteric artery as most commonly seen in the cases of dissecting aneurysm involving peripheral artery. However, it can be seen in any layer of vessel such as in the subintima or in the media as in other cases of dissecting aneurysm. ◀

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(Continued on page 638)





# the view box

LEON LOVE, M.D., CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

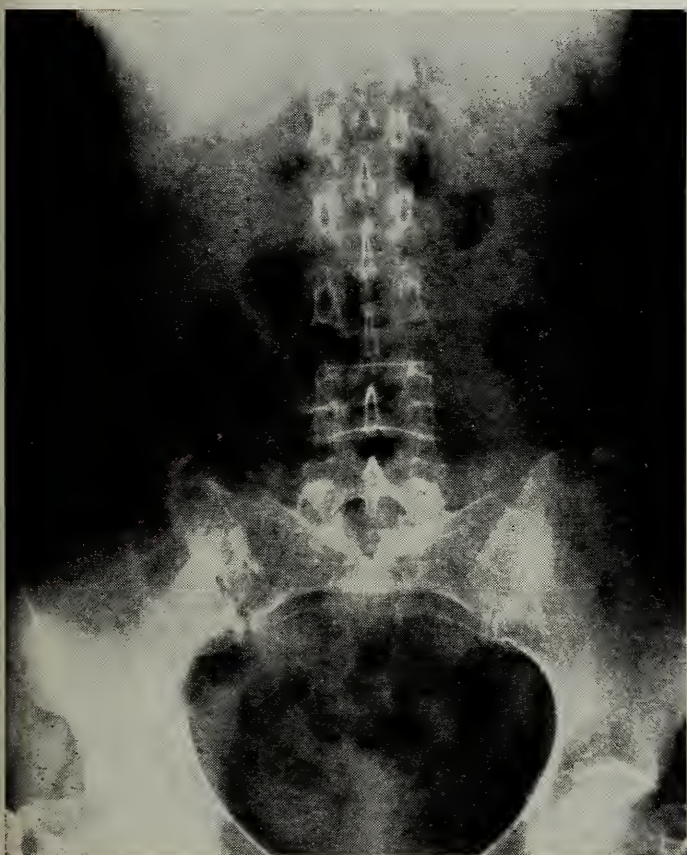


Fig. 1

This 57-year-old female had a history of treatment for carcinoma of the cervix, seven and one-half years previously, at which time she had two radium insertions and external radiotherapy. She did well until about two months prior to her admission, when she began to experience some difficulty with right leg swelling and pain.

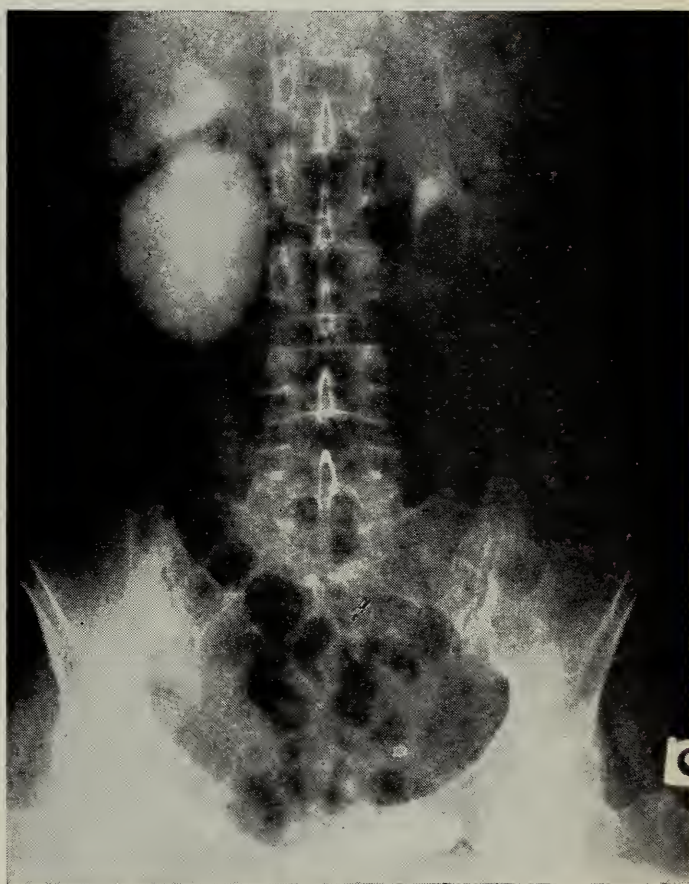


Fig. 2

Abdominal and pelvic examination were essentially normal. What's your diagnosis?

1. Congenital uretero-pelvic obstruction with hydronephrosis.
2. Recurrent carcinoma with lymph node metastases and compression of the uretero-pelvic junction.

(Answer on page 640)





## surgical grand rounds

*Surgical Grand Rounds are held weekly on Tuesday at 5 p.m., in Offield Auditorium, Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the usual basis of the discussions. This case report was part of the Surgical Grand Rounds of July 28, 1970.*

# Vesicoureteral reflux

EDITED BY JOHN M. BEAL, M.D.

### Case Report:

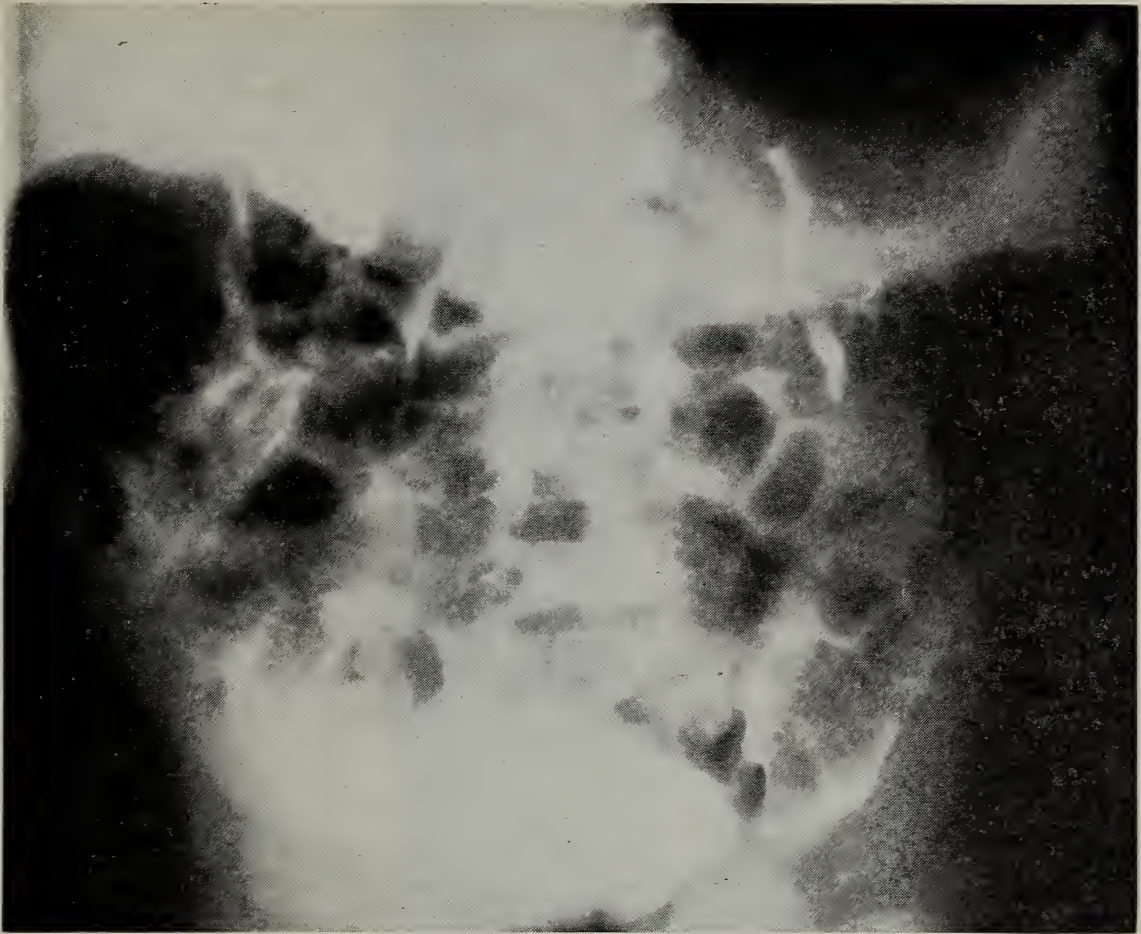
**Dr. Kenneth Simons:** A nine month old, white, female child was admitted to the Urology Service of Chicago's Children's Memorial Hospital with a one month history of recurring fever, abdominal pain and pyuria. Gantrisin was administered for the first episode and she responded well for several days. However, evidence of urinary infection reappeared and she was treated with Ampicillin. Again, she did well for several days but the infection occurred once again. Physical examination was unremarkable except for mild bilateral flank tenderness. Blood count was normal. Urinalysis showed numerous white blood cells. Assay of renal function revealed a BUN of 18 and creatinine of 0.5 mgm.%.

**Dr. Abram Cannon:** The excretory study on the IVP shows the calyces and pelvis with the ureters draining into the bladder, without evi-

dence of abnormality (Fig. 1). The voiding cystourethrogram shows marked reflux into each ureter, demonstrating marked dilatation of the calyces and pelvis of each kidney (Fig. 2). There even appears to be some tubular backflow.

**Dr. Simons:** Cystoscopy was performed and calibration of the ureteral orifices carried out. Both were patulous without evidence of a submucosal tunnel. It was therefore concluded that the patient would benefit from ureteral implantation by an antireflux technique. This was performed through a transverse suprapubic incision using a combined transvesical and extravesical approach to the lower ureter.

**Dr. A. Barry Belman:** Vesicoureteral reflux is a common entity in children, the importance of which wasn't really recognized until the 1950s. Patients present as this child did, with fever



**Fig. 1. Bilateral upper urinary tract visualization was obtained on 10 minute film with intravenous pyelography. Evidence of obstruction was not seen.**

which is often unexplained. The child is treated with an antibiotic and improves, and may shortly thereafter become reinfected and febrile again. Ultimately, the urine is examined, the child has pyuria and on evaluation reflux is found. Because of this entity, a voiding cystourethrogram is part of our evaluation of all children with urinary tract infections.

Normally, upon entering the bladder, the ureter goes through a submucosal tunnel. This tunneling effect allows the ureter to be compressed when intravesical pressure increases, particularly during urination. In some instances, this flap or valve type mechanism doesn't work adequately. For example, in urinary tract infection in children with normal tunnels, there can be relative rigidity of this mechanism and reflux will occur. In the congenital anomaly of a periureteral diverticulum, there is no backing against which the ureter can be compressed and reflux will occur when intravesical pressure increases. There can be various degrees of absence of this tunnel. In the patient presented, there was absolutely no

tunnel present with the ureter entering at more or less of a right angle.

At cystoscopic evaluation of these patients, we look particularly at the ureteral orifice, which normally looks something like a cone with a pin-point opening. There are various degrees of pathology. This child had what is called a "golf hole" orifice. We thought we might be looking at a diverticulum. Depending upon the length of the tunnel, we may see an orifice that looks like a "stadium" or a "horseshoe." These abnormalities are not as severe as the "golf hole" type.

We try to determine the tunnel length on evaluation of these children. When a ureteral catheter is passed into the orifice, by looking at the ripple caused by the catheter, we can estimate how long the tunnel is. We consider a length of about 1 cm. as adequate to prevent reflux.

When do we decide that these children need to have surgical correction of this defect? If they have persistent infection which cannot be controlled by medication, or if there is progressive





**Fig. 2. Voiding cystourethrogram demonstrated bilateral vesicoureteral reflux.**

renal damage, a surgical procedure is indicated.

When operation is performed, a transverse suprapubic incision is used, the bladder opened, the ureter catheterized and disconnected from the bladder using an intra- and extravesical approach. The ureter is dissected proximally to free any kinks which might be obstructive. Approaching the trigone from inside the bladder, we dissect up the mucosa, making a tunnel. An incision is made through the bladder at the cephalad end of the tunnel through which the ureter is brought. The ureter is then brought through the tunnel and sutured to the caudad end at the trigone.

Reflux is an extremely common entity. It is most common in Caucasian girls, in whom it approaches one-half of one per cent of the pediatric population. In the absence of an anatomic abnormality such as periureteral diverticulum, or right angle "golf hole" type orifice, an operative procedure is seldom required. In fact, about 80% of the children with reflux do not require surgery. Treatment of the initial infection may

be all that is required; however, in some patients, long term chemotherapy is necessary. Of those with a specific abnormality, such as periureteral diverticulum, about 75% will require a surgical procedure to rid them of reflux and to hopefully prevent chronic renal damage, which is our ultimate goal.

Reflux also occurs in patients who have bladder outlet obstructions. In children, this is usually either a bladder neck contracture or a posterior urethral valve. In those patients in whom there is not an associated abnormality of the vesicoureteral junction, correction of the bladder outlet obstruction itself will usually result in correction of the reflux. However, in those in whom there is an associated ureteral abnormality, an antireflux procedure should also be done.

The success of surgery is dependent upon the degree of ureterectasis. In a child such as this, who has a normal ureter on intravenous pyelography, we anticipate about an 80-90% success rate. By defining a good result, we would say that the child does not reflux and does not have

stenosis at the site of reimplantation, and remains free of infection. In those who have ureterectasis, the success rate is 60-65%.

You might wonder why there is such a discrepancy between the pyelogram in this patient, which one could perhaps call normal, and the voiding cystourethrogram, which is grossly abnormal. This is simply on the basis of pressure. The bladder is filled and the contrast material is allowed to flow in. The child is made to void by letting the contrast material flow in until urination begins around the catheter. The catheter is removed and films are taken. So this is a relatively high pressure study.

**Dr. John Beal:** How did you happen to do the voiding cystogram after the IVP was normal?

**Dr. Belman:** This is part of our routine with any child presenting with a urinary tract infection. Actually, we do the cystogram first because abnormalities on cystograms are more common than abnormalities on IVP.

**Dr. Beal:** You mean a child of seven months of age should have a voiding cystogram if he has a urinary tract infection?

**Dr. Belman:** We feel that any child below the age of two, including girls, should be evaluated after one urinary tract infection. All boys should be evaluated after their first infection, and girls over two years of age after their second infection, or when a first infection persists in the face of therapy.

**Dr. Beal:** How do they get infected?

**Dr. Belman:** I don't know how they get in-

fectured initially, but one can see why they don't clear themselves of the infection. Every time they void, they push urine up into their upper urinary tracts. After voiding, their bladders are not empty because the urine from the upper urinary tract drains back into the bladder and sits there. If they get one bug in their urinary tract, they have less chance of voiding it out and clearing the infection.

**Dr. Beal:** If you hadn't detected the problem in this child, I assume that the child might well have had repeated bouts of infection and have antibiotics given from time to time.

**Dr. Belman:** I happen to think that not all of these children require surgery. Children with reflux can often be followed safely. Some of these children who actually have a tunnel, but a shortened one, will get to the point where they do not reflux, for one reason or another. In this child, who had an absent tunnel to begin with, we did not believe she fell into this category. However, those children who have a borderline tunnel and are uninfected may eventually develop normal urinary tracts. This child, however, if allowed to go on would probably develop chronic pyelonephritis. Some of the children we are seeing as transplant candidates fit into this group. Some of these children die, some of them get better and have no permanent changes, and others have pyelonephritis and chronic renal disease. All children with unexplained fever require urinalysis and all children with urinary tract infection deserve evaluation.

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## A unique situation: Physicians' relation to hospital

The physicians' relation to the hospital is unique. He is a consumer of its services who does not pay for these services. He is identified as a member of the institutional family but not an employee subject to the employer-employee relation. In addition, he enjoys enormous subsidy from the hospital. Although the hospital does not pay his salary it serves as an important vehicle that permits him to enjoy income. Many of his actual practices are totally dependent upon availability of resources provided by the hospital (instruments, operating rooms, human assistance) for which he pays no fee.

Although medical staff members are appointed for the privilege of enjoying this unique position, the appointment is virtually a sinecure even though subject to periodic review. This does not imply that their acts and actions are totally unrestrained, but they function within the framework of their own bylaws, which are oriented toward organization and professional standards but not administrative relations. The staff members are responsible to each other and to their patients but not to the hospital. (Morton C. Creditor.: *If the Doctors Owned the Hospitals*. *New England Journal of Medicine* (Jan. 21, 1971), 284:3, pages 134-139.)



# Clinical experience with a new laxative in children

BY LESTER A. NATHAN, M.D./SKOKIE

Bisoxatin acetate \* [2,2-bis (p-hydroxyphenyl)-2H-1,4-benzoxazin-3- (4H)-one, diacetate] (Fig. 1) is a new synthetic laxative that acts primarily by stimulating peristalsis of the colon. Experimental studies suggested it may also exert an indirect laxative effect by stimulating increased activity in the distal portion of the small intestine. Bisoxatin acetate has been evaluated abroad and in this country in over 2600 patients with acute or chronic constipation, almost all of whom were adults and many of whom had other primary illnesses for which they received concomitant medications.<sup>1-23</sup> In the majority of these cases favorable or better results were obtained. The few studies that have been done in children also showed excellent results.<sup>18,23</sup> However, it was desired to have more data in this respect, particularly on the use of the compound in otherwise healthy children, giving a clear-cut dissociation between reactions that might arise from the medication and any that might arise from complicating factors.

Although this complaint is not an unusually difficult problem to treat in normal children, there are instances in which re-education of the bowels must be supported simultaneously by a laxative. This paper describes a program in which bisoxatin acetate was used for this purpose.

## Methods

The 88 patients studied, aged one to 17 years, all had a primary diagnosis of acute constipation. Four children had a secondary diagnosis of spastic constipation. The complaints took the form of infrequent movements, small amounts of

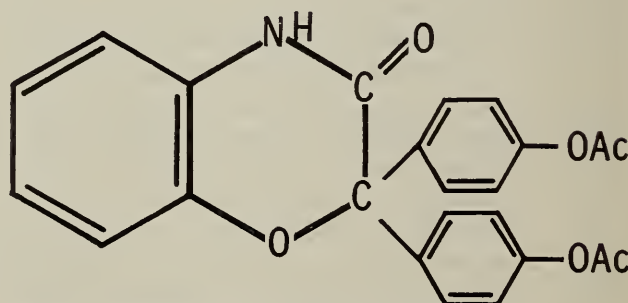


Fig. 1. Structural formula, bisoxatin acetate.

\*Talsis®, Wyeth Laboratories, Philadelphia, Pennsylvania

stool, or hard or firm stool. All the children were otherwise well.

The recommended schedule for administration of bisoxatin was one drop (=6 mg) for each year of age (up to a total of 12 drops/day) to be given in one dose after the evening meal. Mothers of the younger children and the older patients were instructed to modify the dosage as follows: (1) If the response was excessive, the dosage was to be cut by half. (2) If the response was insufficient after three days, the dosage was to be increased by one drop/day (up to 12 drops/day) until the desired action was obtained.

Laboratory tests (hemoglobin and urinalysis) were done for most patients before and after treatment.

### Results

All of the children had a bowel movement within 12 hours after the medication was administered. This fulfilled the criterion of effectiveness. All the responses were rated satisfactory, i.e., the desired action was produced without significant side-effects.

The mean number of movements per day was 1.5 for 26 children who received a total dosage of 36 mg/day, and 1.1 per day for 62 children who received a total dosage of 72 mg/day. Only one child experienced an untoward reaction (tenesmus). No other side-effects of any kind occurred. All laboratory tests for detection of drug-related changes were negative.

The recommended dosage schedule of 6 mg for each year of age was not absolute. Seven children over six years required only 36 mg/day for satisfactory bowel action, while 32 children six years or under received the maximum dosage. In no case was it necessary to exceed this amount.

Bisoxatin was administered from six to 31 days: six to seven days of therapy were sufficient for 22 patients; 43 required medication for up to 14 days; 17, up to 21 days; three, up to 28 days; and three, up to 31 days.

The availability of the compound in liquid form was a decided advantage, especially in the very young children. The drops could be administered alone or diluted with another liquid and the taste was pleasant and unobtrusive.

### Summary

Eighty-eight normal children, aged one to 17 years, with acute constipation received bisoxatin acetate, a new synthetic laxative that acts primarily by stimulating the colon. All of the children achieved a satisfactory response (bowel movement within 12 hours after administration

of the compound without significant side-effects), and only one episode of tenesmus was noted. There were no other untoward effects. The compound was administered for six to 31 days. Approximately 30% of the children required 36 mg/day for effective action, and the remainder received 72 mg/day, the maximum dosage recommended for this age group. ◀

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# Disseminated Chlamydial infection

## Infection by intracellular parasites, Chlamydiae, has a great variance in clinical appearance and increasing frequency of appearance

BY WAYNE M. KASSEL, M.D., GEORGE C. SUTTON, M.D., CLARENCE MACPHARLAND, M.D.,  
AND C. LAURENCE ETHERIDGE, M.D./EVANSTON

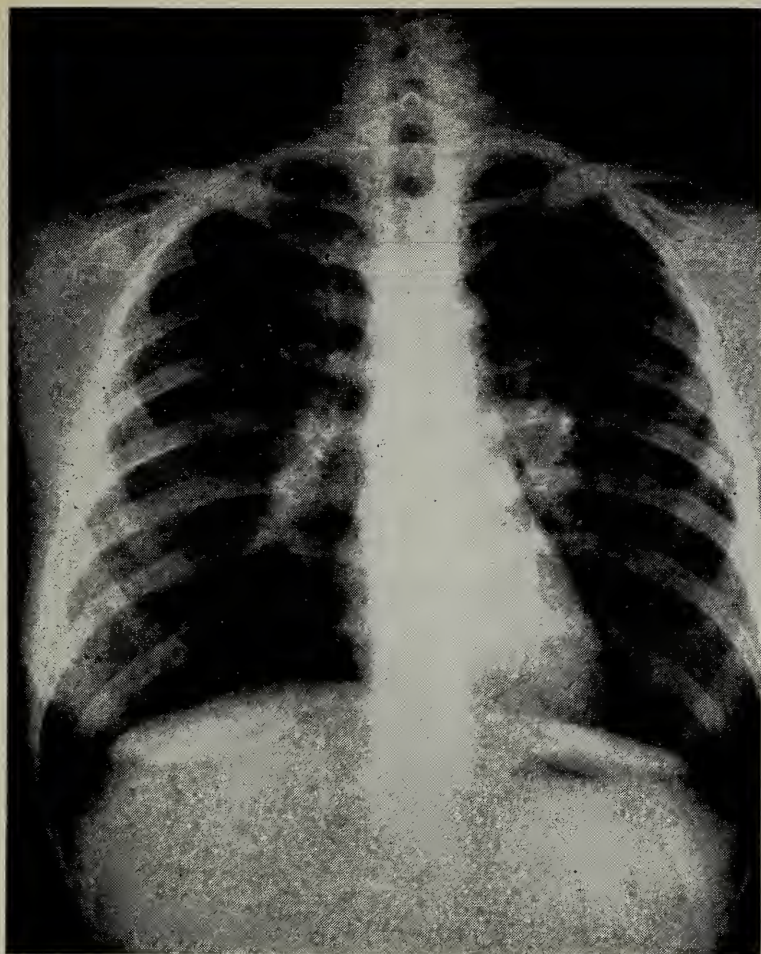
Infection of human beings by the intracellular parasites, Chlamydiae, is unusual in two respects: it is one of the few infections with increasing frequency of occurrence, and there is an increasing variability in the clinical appearance of the disease which may not follow the classic mold of pneumonitis. Pericardial and myocardial involvement have been noted since Adamy's<sup>1-2</sup> description in 1930. Mediastinal lymphadenopathy mimicking lymphoma associated with pericarditis was reported by Sheldon and Associates,<sup>3</sup> in 1948. While vasculitis produced by Chlamydiae has been recognized histologically,<sup>4</sup> and circulatory system "collapse" is a common manifestation,<sup>5</sup> as are adrenal cortical hemorrhages,<sup>6</sup> the production of overt adrenal cortical insufficiency has not been documented. Hence, it seems worthwhile to report the case of a young woman with acute Chlamydial disease in whom serologic confirmation of the infection was demonstrated and which was associated with marked mediastinal lymphadenopathy, pericarditis, and severe adrenal insufficiency.

The case of a 29-year-old woman with simultaneous hilar adenopathy, pericarditis and adrenal insufficiency is presented. Serologic complement fixation and fluorescent antibody studies implicated infection by Chlamydia agent [intracellular parasites] as the cause, although there was no avian vector or pneumonitis. It is postulated that the pathogenesis of Chlamydiae disease may be that of a disseminated vasculites.

### Case Report

The patient, a 29-year-old mother of a healthy eight-year-old child, was first hospitalized in June, 1965, for the evaluation of oligomenorrhea. There were no physical abnormalities ex-

cept for thyroid enlargement (45-50 g.), and a grade ii/vi early systolic decrescendo murmur at the mitral area. The chest X-ray was normal. The 24-hour urine 17 ketosteroid excretion, and



**Fig. 1. P-A Chest X-ray taken on hospital day #1 showing hilar masses.**

17 hydroxycorticosteroid excretion were 5.4 mg and 7.2 mg respectively. (Normal 17 KS, 5-15 mg, 17 OHCS, 3-11 mg). A standard oral metyrapone test gave urine 17 KS and 17 OHCS excretions of 5.1 and 12.7 mg/day respectively. She was treated first with medroxyprogesterone acetate and later with stilbesterol for a period of 24 months, after which normal menses continued without medication.

The patient was admitted again on February 25, 1969, complaining of the acute onset of diffuse substernal chest pain radiating into both shoulders. This was accentuated by deep breathing and thoracic motion, and alleviated by lying in the prone position. She had become ill

three weeks prior with cough productive of scanty amounts of yellow-white sputum, malaise and fatigue.

On physical examination she was afebrile, the pulse was 112/min., the blood pressure was 104/70 mm Hg. (RAS), and respirations were 20/min. There was generalized hyperkeratosis follicularis. The thyroid gland was not enlarged. There were no palpable lymph nodes. Secondary sex characteristics were normal. The heart was of normal size, heart tones were of good quality, and there was physiologic splitting of the second heart sound. Chest expansion was symmetrical and the lungs were clear to percussion. Crepitant rales were present over the right lung base. The remainder of the physical examination was unremarkable.

The admission chest X-ray revealed bilateral hilar enlargement, a normal cardiac silhouette and clear lung fields (Fig. 1). Laminograms of the hilar masses confirmed the impression that these were enlarged lymph nodes (Fig. 2). An electrocardiogram on the day of admission revealed slight J-point elevation in leads I, II, aVF, and the precordial leads (Fig. 3).

The heterophile agglutination and three L. E. cell preparations were normal. Cultures of the nose, throat, sputum, and bone marrow for pathogenic bacteria (routine flora) fungus and tuberculosis were negative on three occasions. Skin tests for histoplasmosis, coccidioidomycosis and blastomycosis were not reactive. An intermediate strength PPD caused 15 x 15 mm induration at 48 hrs. Histologic examination of the bone marrow, liver, and fifteen scalene lymph nodes were normal. The peripheral blood differential WBC counts revealed 4-21% eosinophils on four occasions; and the total eosinophil count was 863/mm<sup>3</sup> on the twelfth hospital day.

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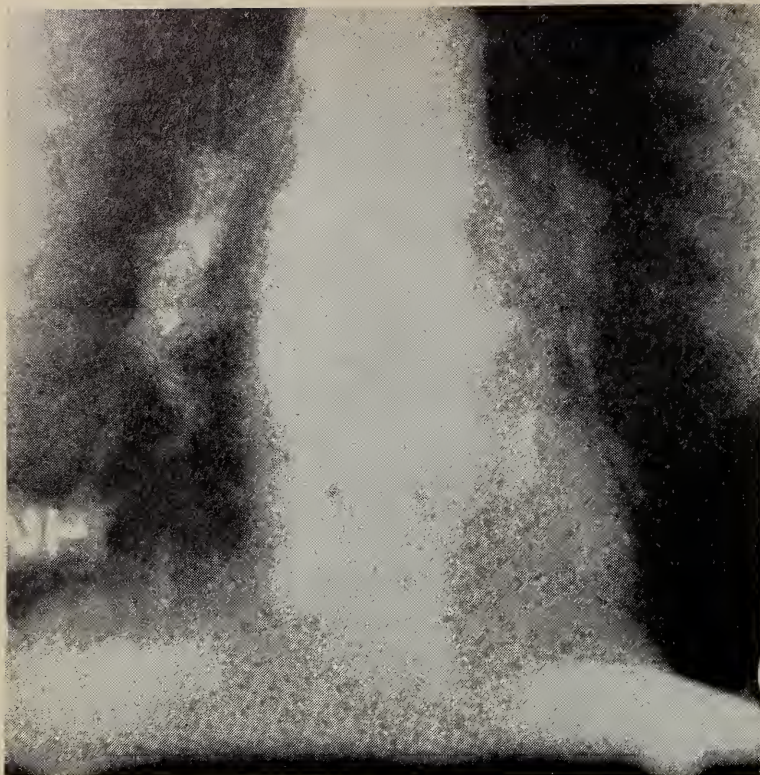
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**Fig. 2. P-A Chest X-ray with laminographic technique revealing bilateral hilar masses to be enlarged lymph nodes.**

On the fourteenth hospital day, bronchoscopy was performed because of the mediastinal adenopathy, and biopsy of the left upper lobe bronchial orifice was obtained. This tissue showed mild to moderate endobronchitis. Cultures of the bronchial aspirations were negative for bacteria. Approximately one hour after bronchoscopy, her blood pressure became unobtainable and the pulse rate rose to 140/min. An ECG revealed no change other than rate. An emergency chest X-ray revealed no reason for the cardiovascular collapse. An indwelling venous catheter was placed at the level of the 4th dorsal vertebrae. Laboratory values obtained at this time are summarized in Table I. Following infusions of 0.9% saline, metaraminol and mannitol, the blood pressure was stabilized with levarterenol. At this time, two hours after the initial fall in blood pressure, the rectal temperature rose to 104°F<sup>2</sup>. Blood cultures were sterile. The serum corticoids obtained at that time were 28 micrograms/100 ml.

**Table I. Laboratory Data  
Three days following bronchoscopy  
and cardiovascular collapse  
(Hospital days 14, 15, and 16)**

Day	Hb	WBC/% Neutrophils	BUN(mg)	Na(mEq)	K(mEq)	Cl(mEq)	CO <sub>2</sub> (mEq)
14	14.5	23800/82	16	125	4.5	97	17
15	11.0	17600/89		136	4.7	102	21
16	9.6	11300/80	5	143		108	23

Nafcillin,<sup>R</sup> kanamycin,<sup>R</sup> and 300 mg. daily of hydrocortisone succinate by the intravenous route were begun. Between the sixth and fourteenth hour after cardiovascular collapse, 3500 cc of fluid were infused. Despite this, urine output fell to 20 cc/hr. With further volume expansion, the urine output rose to 33 cc/hr, and the levarterenol requirements decreased. Nineteen hours after collapse vasopressors were discontinued.

The next day fever continued and signs of consolidation were present over the left lung base. The dosage of steroids was reduced. On the second post-bronchoscopy day to and from pericardial friction rub was audible at the left sternal border. The electrocardiogram revealed diffuse flattening of the T-waves, loss of the previous J-point elevation, and the appearance of biphasic T-waves in the precordial leads (Fig. 3). At this time the serum complement fixing

antibody titer to Chlamydiae group antibody obtained on the second hospital day (2/26/69) was found to be 1:1024. Nafcillin<sup>R</sup> and kanamycin were discontinued and tetracycline, 750 mg. q 6 hrs. was begun and continued for 21 days. Within twenty-four hours the pericardial friction rub had disappeared. A three day I.V. ACTH stimulation test was performed on hospital days 20 to 22. The results are shown in Table II. Because of favorable clinical response of the Chlamydia infection to tetracycline, an attempt to withdraw the patient from steroid supplement was made on the twenty-seventh hospital day. Within 48 hours (day 29), the patient had become hypotensive and febrile and again developed a pericardial friction rub and leukocytosis with a marked left shift. Intravenous hydrocortisone and saline solution terminated this episode in a matter of hours. A second attempt to withdraw dexamethasone on days 39 and 40 led to a third occurrence of adrenal crisis on hospital day 41. The four serial serum complement fixing antibody titers to Chlamydia are tabulated in Table 4; the C F titer fell to a level of 1:2 112 days after admission. Fluorescent antibody studies were performed using serum obtained on the seventeenth day. This serum was conjugated with fluoresceine and reacted with psittacosis agent cultured on chick allantoic membrane\* by the method of Riggs.<sup>7</sup> The results were markedly positive and are illustrated in Figure 4.



Table II.

**24 hour urinary steroid excretion  
in response to intravenous ACTH test**

Hospital Day	17 OHCS (mg)	17 KS (mg)	Urine Vol. (ml)	Urine Cr. (mg)
17*	1.1	0.0	2445	1168
18*	0.5	0.3	2380	1195
19	0.7	0.0	2130	1064
20**	1.7	0.0	1960	1252
21**	2.1	0.0	1895	1286
22**	2.5	0.2	2240	1568

\*Patient received 0.75 mg dexamethasone daily

\*\*Patient given 40 U ACTH in 250 ml 5% D/W IV in 8 hrs. on days 4, 5, and 6.

Table III.

**Serial complement fixing antibody titers  
to chlamydia group antibody**

Date	CF Titer
2/26/69	1:1024
3/10/69	1:512
3/19/69	1:128
4/19/69	1:16
5/16/69	1:4
6/17/69	1:2
1/24/70	0

**Addendum**

Following discharge from the hospital, the patient was maintained on cortisol, 20 mg each morning and 5 mg each evening for a period of

eight months. Once strength had been regained, she remained symptom free. She was admitted for reevaluation in late January, 1970. Her chest X-ray and electrocardiogram had returned to normal. The psittacosis and LGV CF titers were undetectable. The results of ACTH stimulation and metyrapone testing remained consistent with adrenal insufficiency.

**Discussion**

The Chlamydiae are a unique group of obligate intracellular parasites possessing both DNA and RNA and are dependent upon the host cell for generation of metabolic energy. Moulder<sup>8</sup> has emphasized that the differences in biology and chemistry of viruses and Chlamydiae lead to differences in the type and management of the diseases produced.

Chlamydiae are involved in the production of human disease which vary greatly from the classic psittacosis, trachoma, and lymphogranuloma venereum: certain types of arthritis, urethritis, perimyocarditis, and generalized vasculitis have been described.<sup>9</sup> The absence of a demonstrable avian vector in many cases has been noted by Harding<sup>10</sup> and Fraser et. al.<sup>11</sup> Clinically, significant multiple organ involvement may occur frequently. The studies of Schaffner et. al.<sup>12</sup> on the clinical variability, and Yow et. al.<sup>13</sup> on the pathological variability of psittacosis leave little doubt that Chlamydial disease is often a gen-

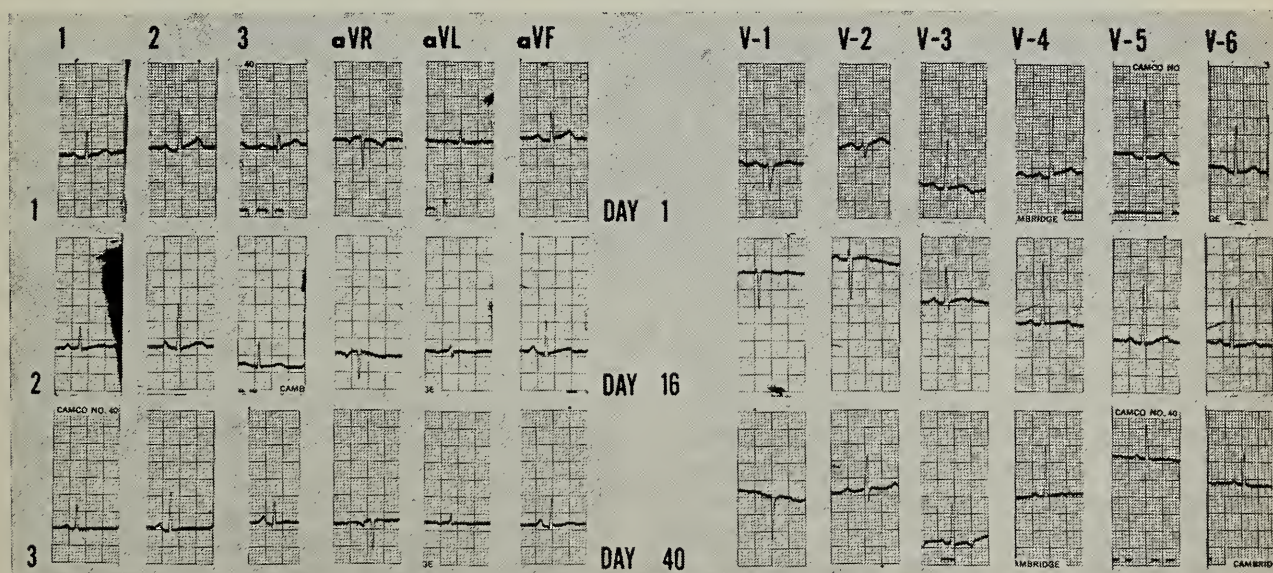
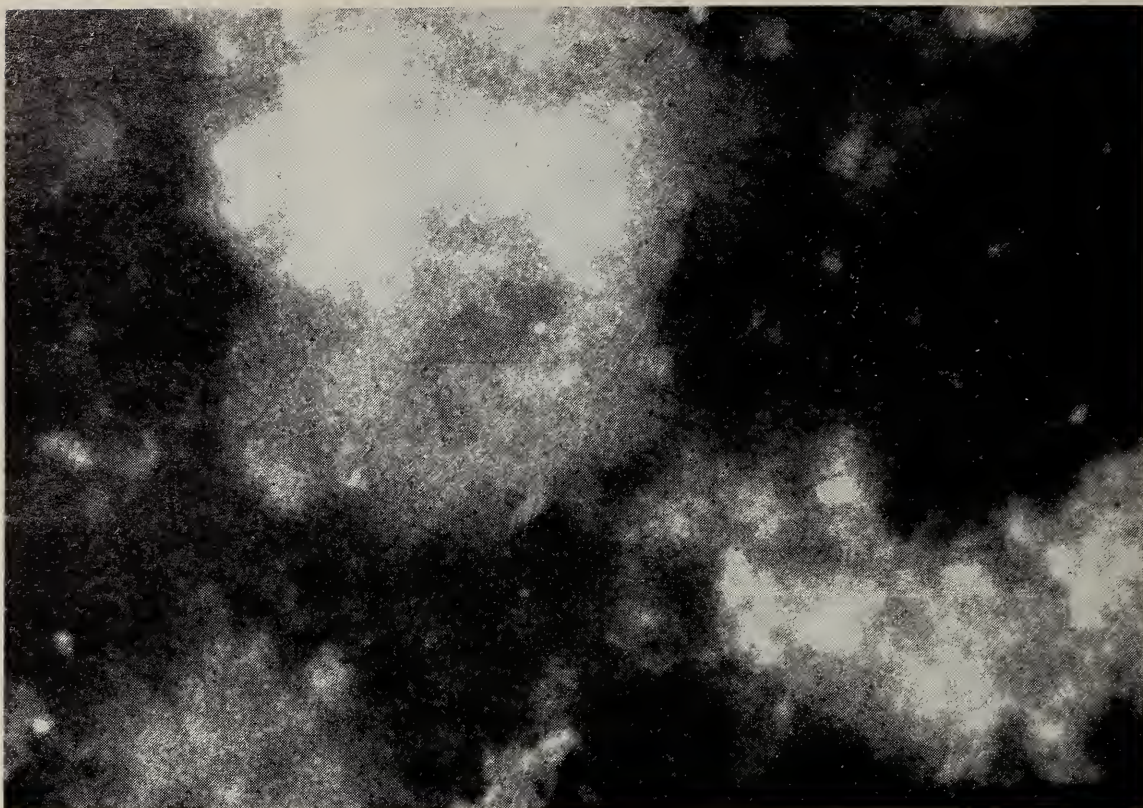


Fig. 3. Electrocardiograms. Hospital day #1. There is slight J-point elevation in leads I, II, aVF, and the precordial leads.

Hospital day #16. There is diffuse flattening of the T waves, loss of the previous J-point elevation, and appearance of some biphasic T waves in the precordial leads.

Hospital day #40. The T waves in the standard and limb leads have remained flattened. The T waves are inverted in leads V-2 and V-3.





**Fig. 4. Fluorescent antibody studies using patient's serum obtained on 3/13/69 and chicken egg cells infected with Chlamydia agent.**

eralized systemic disease with the usual portal of entry being the respiratory or genito-urinary tract. The frequency of small and medium arterial thrombosis, glomerular hyalinization and thrombosis, and adrenal petechial hemorrhage is striking.

Our patient initially failed to show radiologic evidence of pulmonary parenchymal disease, had no fever, and gave no history of bird contact. This case did reveal remarkable serologic and fluorescent antibody evidence of Chlamydial infection, hilar lymphadenopathy, and pericardial involvement as shown by the electrocardiogram and by a recurrent pericardial friction rub. The previously unreported adrenal insufficiency in acute Chlamydial infection was documented by: a low blood cortisol level, (especially considering the remarkable stress), poor response to ACTH stimulation, and most significantly, the inability of the patient to subsist without hormonal replacement therapy. While the Chlamydia infection might have been fortuitous, it is probable that the adrenal cortical failure was the result of vascular lesions previously described in Chlamydial infections. The pathogenesis of Chlamydial disease may actually be that of a disseminated vasculitis.

The purpose of this illustrative case report is to call attention to the fact that Chlamydial

disease may present as an obscure multisystem disorder, without benefit of the usual pulmonary parenchymal or historical clues usually associated with the disease. ◀

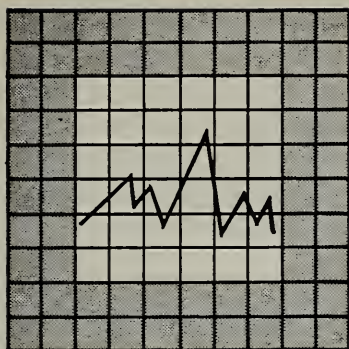
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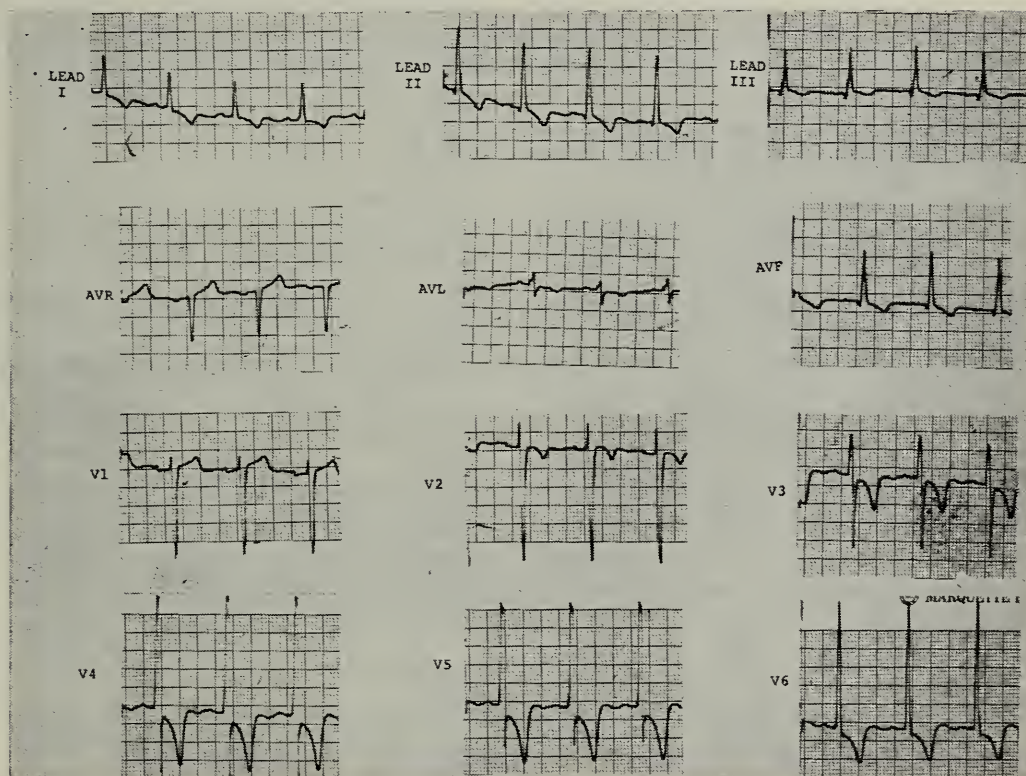
\*This preparation was supplied through the courtesy of Dr. Julius Schacter, G. W. Hooper Foundation, San Francisco Medical Center, School of Medicine, San Francisco, California.





# ekg of the month

JOHN R. TOBIN, JR., M.D., M.S., RIMGAUDAS NEMICKAS, M.D.  
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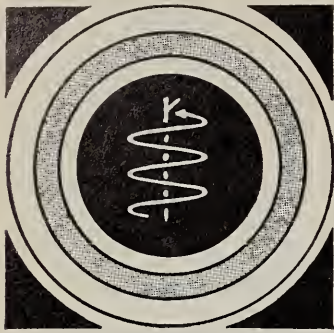
The patient, a 49-year-old, white male was admitted with complaints of syncope of two years duration, compressing exertional chest pain of one year duration, and progressive dyspnea of two months duration. Examination revealed a B/P of 120/70. Palpation of the carotid artery disclosed a bisferiens pulse with a delayed secondary peak. Palpation of the precordium disclosed a forceful sustained PMI in the 5th and 6th intercostal spaces outside the mid-clavicular line.  $S_1$  was slightly accentuated at the apex and was closely followed by an early systolic ejection click (ESEC).  $S_2$  was diminished in intensity at 3L, particularly the aortic component. A 4/6 systolic ejection murmur, present at 2R, radiated

into the carotids. A diastolic decrescendo murmur was present at 3L. The ECG showed a rate of 84, PR 0.16, QRS 0.08, and QT 0.38. Frontal plane axis is  $60^\circ$ .

**QUESTIONS** (One or more of the following statements may be correct):

1. Left ventricular hypertrophy is present.
2. Right ventricular hypertrophy is present.
3. A palpable sustained PMI suggests left ventricular hypertrophy due to pressure over load.
4. Aortic stenosis and regurgitation is present.
5. A bisferiens pulse in the carotid artery suggests the presence of a combined lesion of the aortic valve. (Answer on page 640)





## medical progress

# Drug therapy in alcoholism

**It is especially important in the prevention of such complications as seizures, DT's, Wernicke's Encephalopathy, or polyneuritis.**

BY VERDAD OGE, M.D./MISSOURI

Alcoholism is one of the most complex, chronic, progressive and destructive diseases. Although most publicized reports estimate an alcoholic population of six million people in the United States, a more accurate figure is far above this number. Since alcoholism is so common and its intoxication and withdrawal presents a serious medical emergency, the treatment of alcoholism must be a part of the professional skills of every practicing physician.

The most successful way to treat alcoholics is the multi-disciplinary approach. Drug therapy is the most important part of this total treatment approach; it is especially important for the treatment of acute alcoholic intoxication and withdrawal and also for the prevention of the serious complications like seizures, DT's, Wernicke's Encephalopathy, or polyneuritis. By using proper drugs, the patient's disturbed behavior, severe psychomotor agitation, and depression are controlled with minimum sedation and the patient becomes eligible for further individual and group psychotherapy for his addiction.

Ethyl alcohol is a drug, the most common of the sedative drugs; like other sedatives, it is a very addictive drug. Its addiction produces very strong physical and psychological dependency and tolerance. Since the physical dependence is so great, withdrawal symptoms are very alarming and serious. The withdrawal sickness from

narcotics is less severe and less serious than from alcohol. Addicted individuals rarely, if ever, die from narcotic withdrawal, but death from alcohol withdrawal is quite common.

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*\*Presented at the Third International Congress of Social Psychiatry, Zagreb, Yugoslavia, in September, 1970.*

Concerning their treatment, alcoholics can be put into two different categories:

**I. Patients needing immediate treatment for symptoms associated with acute alcohol intoxication and its withdrawal.** Drugs for these purposes can be put into three groups:

1. Drugs for the correction of the primary acute metabolic and physiological disturbances.
2. Drugs for the reduction of the secondary symptoms of the alcohol intoxication like severe anxiety, depression and psychomotor agitation.
3. Drugs for the prevention of impending delirium tremens, convulsive seizures, peripheral neuropathy, and Wernicke's Encephalopathy.

**II. Patients needing long term rehabilitation designed for weaning them from their dependence on alcohol.** There are certain drugs for use in this stage, like deterrent drugs and LSD.

Drug therapy is especially important for patients in the first category who are suffering from acute alcohol intoxication or withdrawal disease. The selection and use of drugs in the treatment of alcoholism depends on the:

- immediate needs of the particular patients
- severity of alcohol intoxication or withdrawal symptoms
- presence or absence of associated disease or complications

However, it should be kept in mind that:

First, we are dealing with an addictive prone individual who is basically suffering from a sedative addiction and its withdrawal. Therefore, drugs we use in this treatment should not produce dependency or addiction.

Secondly, almost all alcoholics, if not all, have a certain degree of liver damage, there-

fore, we must be concerned with the toxicity of the drug used. Drugs which impair the liver function—(i.e. precipitate cardiovascular shock or increase CNS excitability, etc.), should be avoided.

Thirdly, if we are dealing with an acutely intoxicated patient, the drugs we use should prevent—not precipitate—withdrawal symptoms, and should not produce synergism with alcohol. There is a risk of drug therapy in the patient suffering from an alcohol intoxication as in the case of combining the psychotropic drug with ethanol (paraldehyde).

The drying out process, or detoxification, of the alcoholic patient is the first step in all approaches to the rehabilitation of alcoholics. Detoxification is not a simple or smooth process for the patient. On the other hand, treatment and care of the acute intoxication and withdrawal syndrome makes heavy demands on the staff at the treatment centers, and requires a great deal of knowledge and experience.

One of the most dangerous complications of acute alcohol intoxication is alcoholic coma, which always presents a medical emergency. Immediate complete physical and laboratory examinations must be done for differential diagnosis and for the determination of the depth of the coma. In alcoholic coma there is always the danger of death from respiratory depression or circulatory collapse. Other types of intoxications, head injuries, subdural hematoma and other diseases must be ruled out before the patient can be considered to be intoxicated only from alcohol.

Hemiplegia, diabetes, hypoglycemic coma, cerebral concussion, and other drug intoxications might give the appearance of acute alcohol intoxication if the patient with such a condition also has been drinking.

## Drugs for the Correction of the Primary Acute Metabolic and Physiologic Disturbances

In the treatment of acute alcohol intoxication or its withdrawal state, special attention should be given to water, electrolyte, acid-base metabo-



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lism, and unstable blood glucose. A number of investigators have demonstrated that ethyl alcohol acts as a diuretic, due to suppression of the release of the antidiuretic hormone from the posterior pituitary. Therefore, a sufficient amount of alcohol ingestion is followed by a substantial diuresis. However, this is the acute effect of alcohol in the organism which occurs while the blood alcohol level is increasing and fails to be maintained if the blood alcohol level is kept steady even at the high level or while decreasing. This diuresis can be completely in-



hibited by post pituitary extracts. During the diuresis caused by alcohol, there is no increase in the excretion of Na, K, and Cl in the urine. In fact, there is retention of these electrolytes in the organism. Retention of these electrolytes in the organism would cause hypertonicity of the extracellular fluid. In order to reduce the hypertonicity, individual increases in daily water intake by the thirst mechanism can produce overhydration. In fact, more cases come to the treatment center in a state of overhydration with the retention of Na, K, and Cl than from dehydration. Some of these cases require the use of diuretic drugs. Of course, dehydration is common in those cases who have been vomiting or have had diarrhea or severe perspiration as a result of acute intoxication or DT's. Therefore, on admission, each patient's electrolytes and water metabolism should be carefully checked, and dehydration and overhydration must be distinguished. It is most important that intravenous fluid is given to dehydrated cases only. Administration of I.V. fluid as a routine therapy for acute alcohol intoxication or chronic alcoholics might produce very serious complications which are sometimes very hard to correct. During acute alcohol intoxication, the most prominent clinical symptoms are those of irritability and psychomotor agitation. These symptoms are often due to existing brain edema as a part of overhydration. There is no doubt that administration of I.V. fluids to someone in this condition would worsen the clinical condition of the

patient. It is unlikely that while alcohol causes the retention of Na, K, and Cl in the organism, it causes a decrease of magnesium by increased urinary excretion. Magnesium plays an important role in the central nervous system and depletion of magnesium results in hyper-excitability of the central nervous system, tremor, tetany and even convulsive seizures. In these cases parenteral magnesium must be given in order to alleviate the magnesium deficiency. During the acute alcohol intoxication or withdrawal, professional attention should also be given to unstable blood glucose. One of the initial biochemical lesions in the liver caused by alcohol is a depletion of glycogen stores and an inhibition of glucogenesis. The blood glucose level is extremely labile in acute withdrawal patients. Hypertonic glucose tends to stabilize the glucostatic mechanism.

There are certain drugs in this group which some investigators felt might be helpful in the treatment of acute alcohol intoxication by accelerating the rate of metabolism of ethyl alcohol in the organism. However, they have not been substantiated. Among these drugs are: Thyroxine, Pyruvate, Pyridoxine and Diphosphopyridine nucleotide (DPN).

A specific adrenal deficiency has been suspected as the case of delirium tremens, but it is now clear, from several studies, that the administration of ACTH or adrenal corticosteroids does not improve the course of the illness in any way.

### **Drugs for Control of Severe Anxiety, Depression and Psychomotor Agitation In Acute Alcohol Intoxication or its Withdrawal**

In this respect, we use tranquilizers more than sedatives. Characteristics of the ideal tranquilizer for this state of alcoholism are:

- it must relieve anxiety with minimum sedation
- it must not be habituating
- it must not impair the physiological recovery
- it must not be toxic for the liver
- it must not promote hypotension
- it must not precipitate seizures

Sedatives should not be used in acute alcohol intoxication or its withdrawal phase since the main disease of the patient is sedative intoxication. Sedatives, like paraldehyde, barbituates or chloral hydrate, always risk oversedation of the patient which can often result in a therapeutic catastrophe. Basically, they are extremely addictive, they are toxic for the liver, and

they have synergism with alcohol. Therefore, the popular use of paraldehyde for acute alcohol intoxication during recent years has been replaced by tranquilizers.

*Chloropromazine* (Thorazine) has been used in both acute intoxication and withdrawal. It is rapid in action, effective for control of psychomotor agitation, but its toxic effect on the liver may produce hypotension and might also produce seizures.

*Promazine* (Sparine) is very effective for psychomotor agitation but hypotensive effect is more than other tranquilizers, and it may also precipitate seizures.

*Thioridazine* (Mellaril) is also effective on psychomotor agitation. It's not as toxic to the liver as the other tranquilizers. It doesn't precipitate seizures, but it produces hypotension and there is no injectible form.

*Chlordiazepoxide* (Librium) is valuable in the treatment of the acute and chronic phase of alcoholism as a mild tranquilizer. Many therapists feel that Librium is the most appropriate drug in the treatment of alcoholism. Side effects are much less than other tranquilizers; however, in high doses it easily produces over-sedation, and if given by mouth has addictive ability.

*Valium* (Diazepam) is a mild tranquilizer with some anti-depressant effect. It may also be used IM adjunctively in convulsions.

*Hydroxyzine* (Vistaril) is very effective as a mild tranquilizer—especially for psychomotor agitation. It might be used in acute intoxication and withdrawal. It can be given IM or PO.

No side effects have been reported, or over-sedation. It doesn't precipitate seizures, and it is not addictive.

Depression is another common symptom in alcoholics, especially during the detoxification and withdrawal period. In these cases antidepressants such as Amitriptyline Hydrochloride (Elavil) and Imipramine Hydrochloride (Tofranil), should be used.

If a combination of anxiety and depression is present, combined drugs should be given like Etrafon (Perphenazine and Amitriptyline) or Triavil, which is the same combination. Doxepin Hydrochloride (Sinequan) is also a very effective drug for the control of anxiety and depression in alcoholics.

### **Drugs for the Prevention of Impending Delirium Tremens, Convulsions, Peripheral Neuropathy and Wernicke's Encephalopathy**

Hypoglycemia, brain edema, and magnesium deficiency are all important factors in the etiology of delirium tremens. Therefore, in order to prevent impending DT's:

- a. Blood glucose should be stabilized. If hypoglycemia is present, it should be corrected by I.V. hypertonic glucose administration.
- b. If there is a magnesium deficiency, it should be corrected by giving parenteral magnesium.
- c. If over-sedation and brain edema are present, it should be corrected by proper diuretics.
- d. Anxiety, tremor, and psychomotor agitation must be controlled by using proper tranquilizers (which have already been discussed).

- e. Concerning the prevention of convulsions, we used Dilantin almost as a routine (Average dose, 100 mg. t.i.d.). If the patient is already having seizures, Dilantin might be given IM and should be combined with phenobarbital IM until convulsions are controlled. IM Valium injection is also effective for the prevention of convulsions.
- f. Malnutrition and vitamin deficiency should also be corrected. All vitamins, especially Vitamin B complex, Thiamine, should be given sufficiently. Thiamine has a very important effect in the control of central nervous system complications like Wernicke's Disease and also peripheral neuritis.

### **Deterrent Drugs (Antabuse) and LSD in the Treatment of Chronic Alcoholism**

#### **Antabuse Treatment:**

Antabuse (Disulfiram, tetraethylthiuramdisulfide) is a deterrent drug that enforces sobriety and can be used as part of a total treatment for alcoholism. It provides a concrete reason for not drinking and helps the patient remain sober.

In 1947, Drs. Hald and Jacobsen of Denmark accidentally discovered that if alcohol is drunk while Antabuse is in the system, very disagreeable symptoms can result. This discovery led to the use of Antabuse as a deterrent medication in 1948. At the beginning, it was used in very high doses (one to four tablets each day) and those who drank alcohol with Antabuse developed very serious reactions with extreme hy-

pertension, shock, and even death. Since then the methods of use have changed. At the present time, the usual dose is one tablet (or .5 gram) daily for five days, with a maintenance dose thereafter of one-half tablet (or .25 gram) daily which may be continued for months or years. In these doses there are no side-effects or contraindications due to its use, except a decompensated heart disease. However, larger doses may cause side-effects of drowsiness, fatigue, headache, skin rashes and constipation.

Until recently it was felt that Antabuse produces its effect by blocking an enzyme which is necessary for the breakdown of acid aldehyde,



an intermediate product of alcohol metabolism. As a result, acid aldehyde rapidly builds up in an organism and produces these toxic effects. A recent study, however, suggests that Antabuse may combine with alcohol to produce a new toxic compound which is responsible for the toxic antabuse-alcohol reaction. Most of the symptoms experienced in an Antabuse reaction seem related to peripheral vasodilation with appropriate hypotension. The most common symptoms are flushing of the skin, especially the face, with a feeling of heat. Other symptoms include a feeling of weakness, nausea, vomiting, headache, palpitation and fainting. Of course, Antabuse could not possibly be considered a total therapy in itself. The patient should never be given Antabuse against his will or without his full knowledge, consent and understanding.

### LSD Therapy:

Between 1950 and the early 1960s, there was wide use of LSD in the treatment of alcoholism in different countries, but mainly in Canada and the United States. LSD treatment begins, of course, when the patient is sober and its objective is to keep him sober. LSD changes the patient's attitudes so that he no longer needs to drink. In Canada, Drs. Hoffer and Hubbard used LSD on many alcoholics and they reported their results as "encouraging."

In 1962, Dr. O'Reilly and Genevieve Reich reported on a study of 33 alcoholics who had been treated with LSD and then followed for 88 weeks. Seven of these alcoholics were much improved, 10 were somewhat improved and 16 were unchanged.

Drs. O'Reilly and A. Funk reported on 68 alcoholics who had been treated by LSD between 1959 and 1962. Thirty eight per cent were much improved and many of the others were not drinking as much as before. In California, the results of the LSD treatment are about the same. According to Dr. Savage in 1962, of a group of 20 hospitalized alcoholics given LSD, half had stopped drinking at follow-up. Another series of Dr. Savage's 24 cases reported, 17 were better, six were unchanged, and one was worse.

There are other studies concerning LSD therapy in alcoholism. These studies are all remarkably alike.

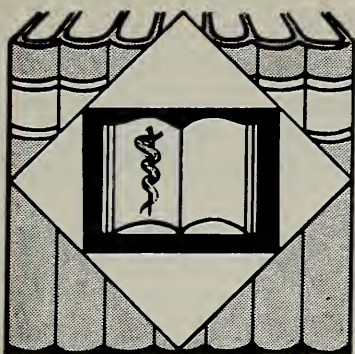
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### Who said a "sick" economy?

Our economic system produced as much in goods and services last year as the combined output of Russia, Japan, West Germany, France and the United Kingdom, the U. S. Commerce Department reports.



## the doctors library

**The Psychodynamic Implications of the Physiological Studies on Dreams.** Edited by Leo Madow, M.D. and Laurence H. Snow, M.D. Springfield, Illinois, Charles C. Thomas, 1970. XIV + 167 pages. \$10.50.

When the historian of science comes to study 20th century American research, one of the strangest phenomena he will deal with is the proliferation of symposia on sleep and dreams. A subject avoided for years as being non-scientific, became in the brief span of a decade and a half one of the most glamorous fields of research known to the behavioral sciences. Official support by governmental agencies, private foundations, educational institutions and drug houses became immense, vast duplications of laboratory facilities and research programs occurred, books, abstracts, and papers, both for scientific and lay viewers increased geometrically. An evaluation of the fruits of this work is badly needed, and while the present volume is a fair introduction to the entire field, it is a flawed product.

The work reported within the volume was presented four years earlier at a symposium held at the Women's Medical College of Pennsylvania in November, 1966. Such a publication lapse raises the serious question of whether the theoretical views presented by the participants are their current views or not.

Dement's paper, aptly entitled, "A Sleep Researcher's Odyssey: The Function and Clinical Significance of REM Sleep," contains a specific disclaimer renouncing "all of my previous and retrospectively premature guesses about these matters . . ." Since the disclaimer applies to work published in the same year as the symposium reported herein, and since Dement is one of our most effective researchers and speculative thinkers, one wonders if the present article really represents his current views.

Fisher's chapter, "Some Psychoanalytic Implications of Recent Research on Sleep and Dream-

ing," on the other hand, does not represent a change in theoretical position as did Dement's paper, but rather takes newer research into account within the formulations Fisher previously presented.

The title of the symposium was poorly chosen. Of the six papers presented, only Fisher's really deals with psychodynamics in the usual sense of the term. Juvet, in a magnificent summary paper, presents present knowledge of the neuro-humoral basis of sleep in an organized fashion, Hartman discusses the pharmacology of sleep, Snyder the introspective phenomenology of dreaming, Whitman, et. al. suggest the use of electrophysiologically monitored dreams in treatment and supervision.

Discussion is presented of the Whitman, et. al. paper, but not of any of the other papers. While the Dement contribution is listed with three collaborators, its title and its style—a quasi autobiographical account—would be more appropriate to single authorship. There are no indices. The price of the volume is high considering the text runs a mere 167 pages.

Edward A. Wolpert, M.D., Ph.D.

**A Biographical History of Medicine.** By John H. Talbott. Grune and Stratton, Inc. 1970, 1211 pages (included are two indexes—name index and subject index).

For more than 10 years, a series of biographical essays appeared in the *Journal of the American Medical Association*, which was under the editorship of John H. Talbott. Many of these essays were used in the preparation of this book. Each was revised, expanded, and reviewed by competent authorities to make the presentations as accurate as possible. The line drawings were prepared by Gabriel Bako.

This book contains the usual biographical ma-



terial on the giants of medical science. Talbott also has included excerpts of material published by these individuals. The essays are grouped by specialties within an era. Grouping of the disciplines adds considerably to the value and interest of the book. Many of the essays had to be translated into English from foreign books and manuscripts. Thus, we are able to read excerpts of a treatise on plastic surgery of the nose by Tagliacozzi who lived in the sixteenth century. Or you may prefer to read a few selected paragraphs on scurvy or contagion by James Lind whose theories ultimately improved the health and living conditions of seafarers. Lind's observations were confirmed by Captain James Cook whose biography is also included.

Many great figures in contemporary medicine were omitted. But Talbott made space for Osler, Fallot, Steell, Banti, Strumpell, Milroy, Mackenzie, Einthoven, Vaquez, Herrick, Ayerza, Keith, Lewis, Still, Wilbur, Murri, Ewing, Frohlich, Minot, Banting, and Florence Sabin.

T. R. Van Dellen, M.D.

#### **The Neonate with Congenital Heart Disease.**

By R. D. Rowe and Ali Mehrizi. 1968. W. B. Saunders Co., West Washington Square, Philadelphia, Pa. 19105. Illustrated, 445 pages. \$12.50.

Death is all too likely to cut the life of the young child with congenital heart disease very short; indeed often within a week or 10 days after birth. If he is to be salvaged, pediatricians and general physicians will need to recognize the condition in time to recommend and carry out the rather aggressive investigative procedure

necessary for the specialist to bring about a suitable correction of the defect. Rowe and Mehrizi reflect their broad experience with commonly encountered congenital heart lesions at the Johns Hopkins Hospital for these primary physicians without attempting to make an encyclopedic monograph about all the possible lesions in this book.

Five major sections make-up the book: an introduction, 10 major cardiac malformations, 10 less common disorders, the rare anomalies, and the related problems. The introduction of 119 pages will be particularly useful for the orientation of a practicing physician into the disorders to be expected and the techniques for demonstrating their presence. Although every physician has gone through the techniques of physical examination, the peculiar problems of evaluating the stage of oxygenation of the newborn, his respiratory responsiveness, and the appreciation of the cardiac activity are not identical to those encountered later in life. Likewise, the electrocardiogram and chest film require a somewhat different frame of reference in the neonate than later in life. Perhaps no one will be satisfied with the relative weight of attention devoted to individual topics but the amount devoted to aortic atresia seems to be clearly excessive. Even with the authors' serious attempts to simplify, the volume of material covered could be rather bewildering. It takes a lot of hard work to master all the material presented and considerable insight to distinguish several respiratory and other disorders from those of cardiac origin in order to salvage these pitiful little "tykes."

William H. Wehrmacher, M.D.

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## ***AMA-ERF grants totaling \$113,935 go To Illinois' seven medical schools***

Grants totaling \$955,725 are being distributed to United States and Canadian medical schools as a result of contributions during 1970 to the AMA's Education and Research Foundation.

Illinois medical schools received the following monies:

Rush Medical College of Chicago—\$6,241; Pritzker School of Medicine of the University of Chicago—\$15,173; Northwestern U. Medical School—\$28,482; U. of Illinois College of Medicine—\$26,292; Chicago Medical School—\$16,839; Stritch School of Medicine, Loyola U.—\$20,736; and Southern Illinois U. School of Medicine—\$172.

Contributions represented unrestricted gifts from physicians and the Woman's Auxiliary.



## *Soliloquy of a general practitioner*

I am a general practitioner. All through the day and all through the night, seven days a week, I am available. I cover an emergency room at the hospital. You spend the days of your life helping others. If you are young, you lack experience—they want a specialist. If you are old, you are in a rut, no ambition, haven't kept up on things—they want a specialist.

I am a general practitioner. Most people think you are just that because you are not very bright. If you were on the ball you would have been a specialist. You will do though on a weekend or a holiday when they can't reach their own specialist.

I am a general practitioner. I regularly go to my hospital board meetings. If I open my mouth or suggest something, I am a horse's behind trying to run things. If I just sit there and say nothing, I have no interest in the organization and probably should be dropped from the staff.

I am a general practitioner. I try to help with community health problems—Blood Bank, immunization programs, etc. If no incident occurs, they wonder what I am doing there. If

something happens, they ask, "Why didn't you anticipate it and be better prepared to handle it?"

I am a general practitioner. You are expected to keep your public life and private life blameless. If you don't, you are criticized by your following.

I am a general practitioner. When the 2 a.m. auto accident comes to the emergency room you take care of them to the best of your ability. Two years later you are in court with the patient—and a sharp lawyer. You are at their mercy. You read the X-rays that morning at 2 a.m., but they were not accepted in court until approved by the radiologist the following day. You were alone at 2 a.m. that morning. They were dammed glad to see you. You were great until the sun came up. The lawyer was not there then—he was, when the settlement came.

I am a general practitioner. Your work surrounds you. You are a jack-ass, but you love it. The community loves you, and the integrity of your own soul makes you the richest man alive.

Jim Riley, M.D.

## *A doctor "of the people, by the people, for the people"*

**Editor:** Concerning "Doctors of the people, By the people, For the people"

Dear Sir:

On page 348 of the *Illinois Medical Journal*, April issue, there is a statement that "the first entering class planned for September, 1972 has been tentatively set at 25."

The son of a patient who has been with us for many years, wishes to enter medical school; however, his pre-med. grades are not the highest. He did not decide that he wanted to enter medical school until his junior year, which is a bit late to bring up the freshman and sophomore grades. Nevertheless, he comes from a family which would be included in the "salt of the earth" type. He would be willing to spend five years in rural or your type of practice. He has shown himself to be conscientious, co-operative,

courteous, dependable, efficient, and energetic. His character and habits have always been good. It is our opinion that he is thoroughly reliable and will be an asset to the medical profession in whatever community he elects to practice.

He has applied to several medical schools, but has been rejected because of his grades. It is our hope that this program you are setting up will give him an opportunity to prove himself worthy of our confidence and your efforts. Anything you may be able to do for him will be appreciated by us, as well as his family. Thank you.

Name withheld

*Editor's note:* This letter has been referred to Donald Stehr, M.D., chairman of the ISMS Student Loan Fund Committee.





# MEDICAL AND WRITER'S

The American public is shamefu

The Kilander Health Knowledge Test show

1 in 10 believed a child is disfigured if th

As liaison between the medical profession and the public, the medical journalist has responsibilities to both, and as a representative of the press corps, he has obligations to his profession as well. To fulfill these responsibilities and obligations, he needs to have certain intellectual, educational, and ethical qualifications. He needs to understand the process, philosophy, and language of medical science; to appreciate the complexity of its concepts; and to have at least a rudimentary working knowledge of its basic and clinical disciplines. Above all, he should honor its values. He should, for example, defer to traditions established to protect the patient's privacy. To gain the respect of his medical associates, he should never compromise his integrity, and he should conduct himself in a professional manner, never using harassment or asking embarrassing, impertinent, humiliating, or inane questions. He should maintain the highest standards of accuracy and objectivity and should not misuse or falsify science by writing cheap, sensational, or inaccurate stories. He should secure his information through ethical, reliable sources and should not stoop to improper methods and activities.

## The Content of Medical News Report

To serve his educational function best, the medical reporter should cover a wide scope of

subjects, balancing the explosive stories of dramatic discoveries against the less glamorous, but equally important, basic research and daily health problems and hazards. The American public, the most progressive, enlightened, and affluent people of the world, is shamefully uninformed in matters of health. The Kilander Health Knowledge Test, first given 30 years ago and repeated recently, showed that a number of medical myths persist: 1 in 10 sampled believed that a child is disfigured if the mother is frightened during pregnancy, 1 in 6 that tuberculosis is inherited and that fish is a brain food, 1 in 4 that handling toads or frogs causes warts, and 1 in 3 that fever can be "killed" by drinking whiskey.

What can be done about this shocking ignorance? The answer is obviously better health education, and one means of achieving this is through more and better medical stories in the public news media.

The ignorance of even the educated about the reproductive system and their personal complacency about population growth were illustrated in a recent editorial in *Science* (January 23, 1970). In a survey of 1,059 undergraduate and graduate students, as well as faculty members at Cornell University, respondents to a questionnaire showed that "the consequences of sterilization are not generally understood." At

# GOBBLEDYGOOK

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informed in matters of health.

number of medical myths persist:

her is frightened during pregnancy . . .

least half the graduate students, and young biology faculty, who would be expected to be most concerned about the population crisis, recorded a desire for three children or more.

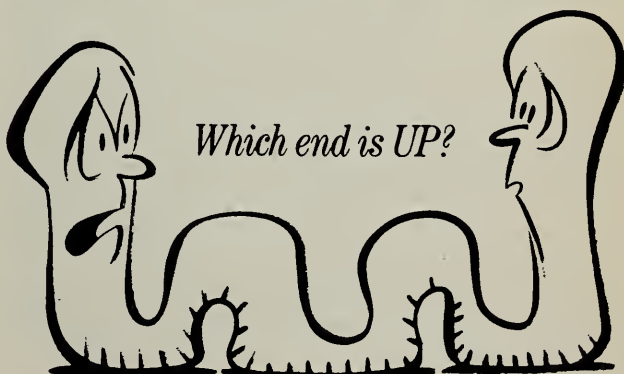
News coverage of the population problem and other important health topics has, in the past, been overshadowed by emphasis on the spectacular and sensational. As one science writer put it, the techniques for reporting scientific information have been adapted from those for reporting crime, fires, and politics, although the events themselves are vastly different.

We would all agree, I believe, that heart transplantation has been drained of its news value—every conceivable aspect of human interest and excitement having been extracted from it, to the neglect of other grave subjects affecting a major portion of our people. The initial intemperate, but widely publicized, claims for the procedure by a few have proved to be scientifically unfounded, and a tacit moratorium on the procedure is in effect, more than two years after the first human heart was transplanted. Ironically, the most vocal of the opportunists now complain bitterly that “ignoramuses” and unfair critics are the ones responsible for the present dearth of donors.

Overplaying a new subject interferes with clear thinking, creates an air of indiscrimination, and hastens the point of diminishing returns, for

news has an extremely rapid rate of deterioration. After the first 50 or so heart transplantations, the average reader was about as interested in reading an account of yet another such operation as he was in drinking last night's unfinished beer. Yet some newspapers continue to headline each such operation by “the world's busiest transplant surgeon,” while burying on obscure back pages each such death. The emphasis on the total number of transplantations performed by a surgeon without disclosure of the mortality rate seems misplaced, particularly when the mortality rate is 100 per cent.

Premature statements about the therapeutic effect of human heart transplants, for example, have since been retracted, but the false hopes they aroused were not so easily banished. The science writer can discourage cavalier statements





# A newspaper headline, "Cannibalizing People"

of this kind if he will expose their authors and if he will seek documentation whenever possible. An operation shifts from being experimental to therapeutic when the rate of success and the incidence of fatal complications warrant this shift, not when an instant "celebrity" decides to say that it has.

The unreliability of press accounts of Dr. Blai-berg's miraculous state of health after his heart transplant operation—as reflected in the contradictory stories published before and after his death—creates distrust of science and scientists in the minds of the public. Although the May 22, 1970, issue of *Life* indicates that Barnard misjudged the value of heart transplantation and states that "The reading, viewing and listening public of the world has been taken on a cruel high, led to believe that miraculous surgery was not only technically feasible but also rewarding, in terms of new and useful life, for the recipients," the publishers of this sensationalistic magazine helped take the public on this "cruel high." Without the aid of the news media, Barnard could not have been presented to the public as "the surgeon of our time," a label to which *Life* takes exception. Only more sober, reliable reporting will eliminate such distortions.

Wild speculation in the press about new medical problems is undesirable, whether it be about the cause of tissue rejection, unproved side effects of drugs, or the possible carcinogenic effect of food additives. The public is not well enough informed to evaluate these statements, and may conclude that the medical scientist depends on will-o-the-wisp ideas and hit-or-miss techniques instead of rational, orderly thought and clear scientific evidence in his search for truth. The competent medical journalist does not allow every self-appointed "authority" who enjoys the sound of his voice to use the news media as a mouthpiece to spout inanities and boast about his feats, but consults reliable sources to verify the accuracy and scientific plausibility of quotations he uses. He takes special care that the content of quotations, when the public may be misled or exposed to danger as a result, is worthy of publication and is valid. At a time when the values of science, along with all human values, are being re-examined and questioned, it is unfortunate if pseudoscientists or publicity hounds are allowed to pose as representatives of serious medical science.

The best source for an opinion on the comparative value of two medical procedures is the man who has done controlled experimental and clinical studies in both.

*Harper's Bazaar*, some time ago, inadvisedly publicized a weight-reduction program that required use of hormones and an injudicious diet.

In the furor over heart transplantation, certain stories serve as examples of journalistic practices to be avoided. In a newspaper article published about a year after Blaiberg's operation, a heart surgeon was quoted as saying: "It might have been better if Blaiberg had died months ago." The casual reader probably focused on the apparent heartlessness of the statement, and did not realize that the ill-chosen words—whether recorded properly or misquoted—were intended to call attention to the false hopes created by extravagant publicizing of heart transplants as a cure-all.

In a newspaper article of October 4, 1968, headlined "Blaiberg Will Get New Heart," Dr. Barnard was quoted as saying that he would eventually transplant a second heart in Blaiberg. Two days later, in an article in the same paper, headlined "Blaiberg Rejects Idea of Another New Heart," Blaiberg expressed dismay and surprise that his physician would announce to the public a plan of further treatment that he had not broached to the patient, and the patient announced that he would refuse the operation. Such news reports have undoubtedly contributed to the present disfavor in which science finds itself.

On September 9, 1968, the *New York Times* headlined an editorial on transplants, "Cannibalizing People," but the article itself was not critical or condemnatory. In the minds of some readers, however, the headline permanently established the similitude of transplant surgeons to cannibals.

An article in *Newsweek*, entitled "When Are You Really Dead?" shortly after the first human heart was transplanted, opened with the shocker, "Doctors can now play God" and quoted a public-health official who had a vision "of ghouls hovering over an accident victim with long knives unsheathed, waiting to take out his organs as soon as he is pronounced dead." This kind of reporting may have sensational appeal, but such a Cassandra outlook seems rather unrealistic, since checks and balances exist within most hospitals.



# made transplant surgeons look like cannibals . . .

Other medical subjects have had their share of misleading articles. A few years ago the *Ladies Home Journal* carried a story entitled "A Jury of Experts Picks America's 10 Best Hospitals," which quoted the director of the Massachusetts General Hospital as saying that there are only a handful of hospitals in the country which he would trust himself to. His hospital headed the 10 best, and he was on the jury that selected them. The article recommended that the public seek medical care in large teaching hospitals. Now less than a fifth of all hospitals fall into this category, and anyone who is informed about such matters knows that some small hospitals offer much better medical care and attention than some large ones. Presuming to select the 10 best hospitals is about as absurd as presuming to select the 10 smartest people in the world or the 10 with the best taste.

The title of an article in *Life*, "It's a Miracle We Save Any of Them," suggests that all hospitals are extremely dangerous. Instead of arousing undue fear and lack of trust, it would have been more helpful to focus on the need to redesign hospitals to care more effectively for patients with cardiac arrest.

There is, of course, a place for public criticism of medicine, but it should be rational and objective, and should be based on sound, factual evidence. (You will agree, I hope, that there is similarly a place for such constructive criticism of news reporting.)

## The Value of Good Medical Reporting

I have focused primarily on faulty medical reporting, in order to point out traps that the medical journalist must recognize, but we have in this country some extremely competent medical journalists who have done a great deal to further health knowledge among the people. These men and women, of the highest intellectual and moral caliber have performed a real public service in helping the average citizen to understand the function and proper care of his body, to recognize early signs and symptoms of illness, to become aware of the many unsolved health problems, and to learn what medical researchers are doing in an effort to solve them. Some young people who have read in the press of the excitement and wonder of medical science, of the remarkable discoveries made and

of their beneficent effects on patients have undoubtedly been inspired to enter a career in medicine. It was press exposure of snakepit conditions in mental institutions a few decades ago that provided the strongest impetus for improvement of conditions in psychiatric hospitals, and the crusading efforts of medical journalists are directly responsible for many other health reforms. The scientific community and society at large owe the professional science writer a real debt of gratitude. And such a professional is understandably disturbed by unreliable or unethical medical reporting whenever it occurs.

## The Role of the Science Information Officer

What can the information officer do to assist in the effective dissemination of medical news to the people? As the middle man between his institution and the press, he can speed the flow of useful information to the public. He can bridge the philosophic and linguistic gaps between medicine and the press by encouraging periodic conferences of scientists and science reporters (and editors, whose presence is even more important), to allow free exchange of ideas, to familiarize each group with the other's approach, attitudes, and needs, and to promote mutual respect and cooperation. For scientists must share with science writers and editors responsibility for faulty science reporting.

The science information officer can furnish background material and assist the reporter in placing the story in proper perspective. He can provide an ethical, reliable source of information and can promote high standards of accuracy, reliability, and propriety. He can encourage greater reliance on primary documented sources and less on word-of-mouth. He can help disseminate the spirit of science and encourage reporters to present its activities as an interminable, rational search for truth, not as a series of isolated, unrelated inquiries and instant, magical discoveries. Finally, he can convey some of the beauty and wonder and excitement of science, and he can arouse an awareness of its resounding impact on our way of life.

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# new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**Single Chemicals**—Drugs not previously known, including new salts.

**Duplicate Single Products** — Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms** — Of a previously introduced product.

**The following new drugs** have been marketed:

## NEW SINGLE CHEMICAL ENTITY

**KEFLEX Antibiotic** R

**Manufacturer:** Lilly

**Nonproprietary**

**name:** Cephalexin (as the monohydrate)

**Indications:** Infections caused by susceptible strains of micro-organisms.

**Contraindications:** Allergy to cephalosporins.

**Dosage:** Adult: 250 mg. every six hrs.

Children: 25 to 50 mg./kg. in 4 divided doses.

**Supplied:** Pulvules, 250 mg.

## DUPLICATE SINGLE PRODUCTS

**BENDOPA Muscle Relaxant-Parkinsonism** R

**Manufacturer:** Bentex, Div. ICN

**Nonproprietary**

**name:** Levodopa (USAN)

**Indications:** Treatment of Parkinson's disease and syndrome.

**Contraindications:** Evidence of uncompensated endocrine, renal, hepatic, cardiovascular or pulmonary disease, narrow angle glaucoma, blood dyscrasias and hypersensitivity to the drug. Do not give when a sympathomimetic amine is contraindicated. Avoid concomitant administration with MAO inhibitors and discontinue inhibitors two weeks prior to levodopa therapy.

**Dosage:** Usual initial dose, 0.5 to 1.0 gm. daily.

Dose must be carefully titrated for individual patient.

**Supplied:** Capsules, 250 and 500 mg.

**LENTE Insulin**

Hypoglycemic R

**Manufacturer:** Squibb

**Nonproprietary**

**name:** Insulin Zinc Suspension (USP)

**Indications:** Diabetes mellitus.

**Contraindications:** None mentioned.

**Dosage:** Individualized.

**Supplied:** Suspension, each cc contains 40 or 80 units.

Also available as SEMILENTE Insulin with small particles for prompt action and ULTRALENTE Insulin with larger particles for extended action.

**LEVOPA Muscle Relaxant-Parkinsonism** R

**Manufacturer:** Smith Kline & French

**Nonproprietary**

**name:** Levodopa (USAN)

**Indications:** Treatment of Parkinson's disease and syndrome.

**Contraindications:** Evidence of uncompensated endocrine, renal, hepatic cardiovascular or pulmonary disease, narrow angle glaucoma, blood dyscrasias and hypersensitivity to the drug. Do not give when a sympathomimetic amine is contraindicated. Avoid concomitant administration with MAO inhibitors and discontinue inhibitors two weeks prior to levodopa therapy.

**Dosage:** Usual initial dose, 0.5 to 1.0 Gm. daily.

Dose must be carefully titrated for individual patient.

**Supplied:** Capsules, 250 and 500 mg.

## COMBINATION PRODUCT

**POLYSPECTRIN Eye**

Preparation R

**Manufacturer:** Allergan

**Composition:** Ointment:

Polymyxin B sulfate  
5000 units/Gm.

Zinc bacitracin  
400 units/Gm.

Neomycin sulfate 5 mg./Gm.

**Indications:** External bacterial infections of the eye.

**Contraindications:** Hypersensitivity to any of the components.

**Dosage:** Apply a small amount to the conjunctival sac several times a day.  
**Supplied:** Steril ophthalmic ointment tubes, 3.5 Gm.

#### NEW DOSAGE FORMS

##### GARAMYCIN

**Ophthalmic Solution**

Eye Preparations R

**Manufacturer:** Schering

**Nonproprietary**

**name:** Gentamicin Sulfate

**Indications:** Infections of the external eye and its adnexa caused by susceptible bacteria.

**Contraindications:** Hypersensitivity to any of the components.

**Dosage:** One or two drops every four hrs.

**Supplied:** Solution, each cc contains 3.0 mg.

**TUSSIONEX Cough**

Preparation R

**Manufacturer:** Strassenburgh Div., Pennwalt

**Composition:** Each capsule contains:

Hydrocodone 5 mg.

Phenyltoloxamine 10 mg.

**Indications:** Long acting antitussive (approx. 12 hrs.).

**Contraindications:** None mentioned.

**Dosage:** One capsule every 8 to 12 hrs.

**Supplied:** Capsules

**KEFLEX Antibiotics-**

Unclassified R

**Manufacturer:** Lilly

**Nonproprietary**

**name:** Cephalexin (as the monohydrate)

**Indications:** Infections caused by susceptible strains of micro-organisms.

**Contraindications:** Allergy to cephalosporins.

**Dosage:** Adult: 250 mg. every six hrs.

Children: 25 to 50 mg./kg. in 4 divided doses.

**Supplied:** Oral suspension, each 5 cc contains 125 mg.

## Huelsenbeck: Finds defeat, searches for chaos

It is a fact that at heart I feel unhappy when I have to function well. And I more and more become aware of the fact that functioning well is the sickness of the American civilization—just about to kill the remaining stock of personal freedom and spontaneity. During my last years in the States, in spite of all my love for American ideals and for American reality, I became sick of my growing success and orderliness. I was in danger of becoming one of those handshaking "How are you" and "How do you do" types that I hate so much. I wanted to be a hippie again, a Dadaist hippie in my own style—with short hair and with a good fitting suit—but a hippie anyway. My desire to be disorderly, chaotic, and malfunctioning, although constantly thwarted by the AMA and my colleagues, became overwhelming. I wanted to go back to some kind of chaos—not a chaos that kills, but a chaos that is the first step to creativity. I more and more hated the physician-businessman type who uses all the tests and all the tricks but is not able to give the patient something substantial that gets him well. I hated the overall moneymaking attitude of the average physician, and I then even hated being a physician.

Here, gentlemen, is my conflict. Being unable to solve it entirely, I try to solve it by changing scenes. It is a mistake. I know it, but this mistake may have curative qualities. I see it from here in Switzerland, where I now live, very clearly: America is a tragic land, and the Americans are a tragic people. Their grandiose try to found a free society has failed, and now they are in an unsolvable conflict. The war in Vietnam, the Negro problem, poverty, and the bankruptcy of the cities—while the arms manufacturers thrive on their income. Gentlemen, America is bankrupt. But I don't claim to be in a much better situation. I want to be a hippie, a doctor, and a moneymaking clever man at the same time. These are unsolvable propositions. (Richard Huelsenbeck.: Huelsenbeck Finds Defeat in America, Returns Home in Search of Chaos. Reprinted from the *American Scholar* 39:1 (Winter) 1969-70. *Psychiatric News* (June) 1970, pages 30-31 & 40.)





## editorials

### Drug combinations and the FDA

The Food and Drug Administration is now considering elimination of almost all combination products. Some are illogical and dangerous, and their removal would create little stir. Prednisone with an antihistamine, for example, combines a drug generally used in a set dosage with another prescribed as needed; an adequate starting dose of the prednisone requires an excessive dose of the antihistamine. This is obviously a poor product.

Other combinations are among the most common prescriptions written, having proven outstanding both at the bedside and often in well-controlled studies. Ephedrine is an effective antiasthmatic drug which makes patients nervous and can cause tachycardia. Several pharmaceutical houses have added phenobarbital to the

ephedrine (often with theophylline) to create a universally accepted product. If this combination were eliminated, the patient could take a capsule of ephedrine with a tablet of phenobarbital, but this would be clumsy and save the patient little, if any, money. Most physicians have similar pet mixtures that make the practice of medicine simpler than prescribing ingredients separately.

Elimination of the useful combinations along with the bad ones would be like throwing out the baby with the bath water. Such a step would create confusion for the patient, chaos for the pharmacist, and a nightmare for the physician. A letter to your senator or congressman might be advisable.

Donald L. Unger, M.D.

### Combination drugs: A therapeutic tool

As a practicing physician, teacher and clinical investigator, I would like to express different views concerning combination drugs with those of the experts whose opinions led to the proposed new regulations.

While, during 40 years of academic and clinical medicine, I have used drug combinations only sparingly and where they were definitely indicated and appeared useful, I nevertheless feel that such combinations have a definite place in therapeutics. The problem of the practicing physician in his daily contact with numerous patients, whether in the office or hospital, is to relieve the patient's symptoms and to get him well. Therefore, the practicing physician uses the drugs with which he is familiar, has obtained best results with the least or no side-effects, and which helped the patient most effectively within the shortest period of time.

If some combinations of drugs have given him such results, he will use them and he will feel deprived of an important therapeutic tool if such a combination of drugs is suddenly removed from the market.

Even in hospitals, combinations of drugs are used at times, not only because they have proven beneficial in patients occasionally so treated, but also because combinations of drugs are occasionally better accepted by the patient who rebels against taking eight to 10 pills or tablets at a time when he could take only three or four with the same therapeutic results.

Regardless of the opinion of the experts, the problem of therapeutic efficacy remains. Physicians would not use any simple drug or any drug combination month after month, and year after year, if they had not encountered good results from the use of this particular drug or drug

combination. Many drugs approved by the FDA gradually disappear from the pharmaceutical market because of poor therapeutic results.

It is my personal opinion therefore that the practicing physician should have available for his use any combination of drugs which he has found useful in the treatment of his patients and which have not given them any serious side-effects. At the same time it is advisable to use possibly more stringent and more elaborate newer techniques in the formulation of newer combination drugs.

With the appearance of better single drugs or better combinations for certain diseases, the old, less efficacious drugs will disappear since the physicians will not be using them.

A sudden removal of useful and time-tested combination of drugs from the therapeutic armamentarium of the practicing physician will not help the patient and will limit the therapeutic effectiveness of the doctor. I am therefore hopeful that the FDA will change its intent of prompt removal of combination drugs from the market.

Frederick Steigmann, M.D.

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## *Twenty-four clinics for crippled children listed for July*

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for July, by the University of Illinois, Division of Services for Crippled Children. The Division will hold 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- July 1 Sterling—Community General Hospital
- July 1 Flora—Clay County Hospital
- July 1 Cairo—Public Health Department
- July 7 Hinsdale—Hinsdale Sanitarium
- July 8 Springfield—St. John's Hospital
- July 8 Macomb—McDonough District Hospital
- July 9 Chicago Heights—Cardiac—St. James Hospital
- July 13 East St. Louis—Christian Welfare Hospital
- July 13 Peoria—St. Francis Children's Hospital
- July 14 Champaign-Urbana—McKinley Hospital
- July 14 Mt. Vernon—Good Samaritan Hospital
- July 14 Joliet—St. Joseph's Hospital
- July 15 Decatur—Decatur Memorial Hospital

- July 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- July 20 Rock Island Area General—Moline Public Hospital
- July 20 Quincy—Blessing Hospital
- July 20 East St. Louis—Christian Welfare Hospital
- July 23 Chicago Heights Cardiac—St. James Hospital
- July 26 Peoria Cardiac—St. Francis Children's Hospital
- July 27 Peoria—St. Francis Children's Hospital
- July 28 Springfield Pediatric Neurological — Diocesan Center
- July 28 Centralia—St. Mary's Hospital
- July 28 Rockford—St. Anthony Hospital
- July 28 Elgin—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



# Index To Volume 139

## January through June, 1971

Page	1-102	January
	103-204	February
	205-304	March
	305-462	April
	461-564	May
	565-646	June

### A

"A circus of ideas" (Davenport) 292 (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**)

"A new approach to the management of refractory psoriasis" (Yarbro and Leavell) 152

**ABSTRACTS OF BOARD ACTIONS** 219, 477

**ACCIDENT.** "The critically injured patient: A plan for the organization of a statewide system of trauma facilities (**SPECIAL ARTICLE**) (Flashner and Boyd) 256

"Alcoholic Treatment: The Group Experience" (**SPECIAL ARTICLE**) (Cook) 514

**ALCOHOLISM**, Drug therapy in (**MEDICAL PROGRESS**) (Oge) 606

Aleem, Mohammad Yousuf, "Gardner's Syndrome" 511

**ANEURYSM**, Dissecting thoracic (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 246

**ANEURYSM** of superior mesenteric artery, Dissecting (Lee and Neiman) 589

#### **ANNUAL CONVENTION**

Delegates Handbook 351  
Program 418  
Instructional Courses 423  
Technical Exhibits 428

**ARTERY**, Dissecting aneurysm of superior mesenteric (Lee and Neiman) 589

### B

Beal, J. M., ed., (**SURGICAL GRAND ROUNDS**) 41; 134; 246; 342; 498; 594

Berschinski, Jean "Why belong to a professional organization" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) 636

Blonsky, E. Richard, "The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease" (Parts I & II) 144, 250 (**MEDICAL PROGRESS**)

**BLUE SHIELD REPORT:** 9; 111; 213; 313; 461; 565

**BOARD ACTIONS**, Abstracts of 219; 477

Boyd, David R., jt. author. See Flashner, Bruce A.

Breed, J. Ernest, "Management of the patient with terminal illness" 503

Breed, J. Ernest, "The 'art' of medicine" (**SPECIAL ARTICLE**) 159

Breed, J. Ernest (**THE PRESIDENTS PAGE**) 26; 115; 233; 317; 474

Brown, Murray, jt. author. See Lane, Robert E.

Butcher, Dan Paul, "Health care delivery crisis" (**SPECIAL ARTICLE**) 349

### C

"Carcinoma in perforated diverticulum of the colon" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 498

**CHICAGO, 1960-1970**, Diphtheria in (Nelson, Kallick and Levin) 35

**CHICAGO (1956-1968)**, Teenage maternal mortality in (Lane and Brown) 241, 337

**CHILDREN**, Clinical experience with a new laxative in (Nathan) 598

Ciric, Ivan, jt. author. See Furey, Warren

"Clinical experience with a new laxative in children" (Nathan) 598

**CLINICS FOR CRIPPLED CHILDREN:** 94; 186; 289; 444; 523; 621

**COLITIS**—A case report, Ischemic (Chandrasekhara and Levitan) 266

**COLON**, Carcinoma in perforated diverticulum of the (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 498

**CONTRACEPTIVE**, "Tubal pregnancy in a patient with an IUD" (DiGiulio) 131

#### CONVENTION

Delegates Handbook 351

Program 418

Instructional Courses 423

Technical Exhibits 428

Cook, Richard S., "Alcoholic Treatment: The Group Experience" (**SPECIAL ARTICLE**) 514

Cowen, John, "The hypochondriacal patient in the physician's office" 66

**CRISIS**, Health care delivery (**SPECIAL ARTICLE**) (Butcher) 349

#### D

Daugirdas, John, "Doctors of the people, by the people, for the people" (**SPECIAL ARTICLE**) 346

Davenport, Irma, "A circus of ideas" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) 292

Debakey, Lois, "Medical Gobbledygook and Writer's Gookledygobb" 614

DeHaen, Paul (**NEW PHARMACEUTICAL SPECIALTIES**) 74; 172; 284; 448; 521; 618

**DELEGATES HANDBOOK**, Annual Convention Program 351

DiGiulio, Vincent S., "Tubal pregnancy in a patient with an IUD" 131

"Diphtheria in Chicago, 1960-1970" (Nelson, Kallick and Levin) 35

**DISEASE**, The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease (Parts I & II) (**MEDICAL PROGRESS**) (Blonsky) 144, 250

"Dissecting aneurysm of superior mesenteric artery" (Lee and Neiman) 589

"Dissecting thoracic aneurysm" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 246

"Disseminated Chlamydial infection" (Kassel, Sutton, MacPharland and Etheridge) 600

**DIVERTICULUM** of the colon, Carcinoma in perforated (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 498

"Doctors of the people, by the people, for the people" (**SPECIAL ARTICLE**) (Daugirdas) 346

Doscher, Crile, "The patent omphalomesenteric duct" 493

"Drug therapy in alcoholism (**MEDICAL PROGRESS**) (Oge) 606

**DUCT STONES**, Recurrent (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 342

**DUCT**, The patent omphalomesenteric (Doscher) 493

**DUODENAL ULCER**: Associated with pneumocystis carinii pneumonitis and dysgammaglobulinemia, Associated with (Farinas and Quel) 138

#### E

**ECONOMICS**: 83; 180; 271; 439; 541; 632

**EDITORIALS**: 75; 170; 288; 437; 534; 620

**EKG OF THE MONTH** (Tobin, Nemickas and Scanlon): 47; 143; 286; 447; 497; 605

Etheridge, C. Laurence, jt. author. See Kassel, Wayne M.

"Expansion of a local effort: The MECO Project" (**SPECIAL ARTICLE**) (Fischer) 155

#### F

Farinas, Enrico T., and Quel, Jorge A., "Hypertension and duodenal ulcer associated with pneumocystis carinii pneumonitis and dysgammaglobulinemia" 138

Fischer, Lee A., "Expansion of a local effort—The MECO Project" (**SPECIAL ARTICLE**) 155

Flashner, Bruce A., and Boyd, David R., "The critically injured patient: A plan for the organization of a statewide system of trauma facilities" (**SPECIAL ARTICLE**) 256

**FOUNDATIONS** for medical care. hmo or fmc? Drastic changes ahead in medical care (**SPECIAL ARTICLE**) 50

Fruin, L. T. (**THE PRESIDENTS PAGE**) 582

Furey, Warren, Ciric, Ivan, and Parker, Richard H., "Monitoring of Intrathecal Polymyxin B Dosage during treatment of pseudomonas meningitis" 507

#### G

"Gardner's Syndrome" (Aleem) 511

#### H

**HEALTH CARE DELIVERY** changes in the 70s. Leadership Conference abstracts (**SPECIAL ARTICLE**) 53

"Health care delivery crisis" (**SPECIAL ARTICLE**) (Butcher) 349

**HEALTH MAINTENANCE ORGANIZATIONS**. hmo or fmc? Drastic changes ahead in medical care (**SPECIAL ARTICLE**) 50

"hmo or fmc? Drastic changes ahead in medical care" (**SPECIAL ARTICLE**) 50



"Hydronephrosis" (SURGICAL GRAND ROUNDS)  
(Beal, ed.) 134

"Hypertension and duodenal ulcer: Associated with pneumocystis carinii pneumonitis and dysgamma-globulinemia" (Farinas and Quel) 138

HYPOCHONDRIACAL PATIENT in the physician's office, The (Cowen) 66

## I

IMAA REPORT: 92; 292; 536; 636

INJURED PATIENT: A plan for the organization of a statewide system of trauma facilities, The critically (SPECIAL ARTICLE) (Flashner and Boyd) 256

INSTRUCTIONAL COURSES, Annual Convention 423

INTRATHECAL Polymyxin B Dosage during treatment of pseudomonas meningitis, Monitoring of (Furey, Ciric and Parker) 507

"Ischemic colitis—a case report" (Chandrasekhara and Levitan) 266

IUD, Tubal pregnancy in a patient with an (DiGiulio) 131

## J

Jackson, Ruby, "Medical assistant must maintain perfection" (ILLINOIS MEDICAL ASSISTANTS ASSOCIATION) 92

## K

Kassel, Wayne, M., Sutton, George C., MacPharland, Clarence and Etheridge, C. Laurence, "Disseminated Chlamydial infection" 600

## L

Lane, Robert E., and Brown, Murray, "Teenage maternal mortality in Chicago (1956-1968)" 241, 337

LAXATIVE in children, Clinical experience with a new (Nathan) 598

L-DOPA in the functional rehabilitation of patients with Parkinson's Disease, The role of (Parts I & II) (MEDICAL PROGRESS) (Blonsky) 144, 250

"Leadership Conference abstracts: 'Health Care Delivery Changes in the 70s'" (SPECIAL ARTICLE) 53

Leavell, Ullin W., jt. author. See Yarbrow, J. W.

Lee, Bak Moo and Neiman, Ben H., "Dissecting aneurysm of superior mesenteric artery" 589

Lotharius, Joseph (SOCIO-ECONOMIC NEWS) 83; 180; 271; 439; 541; 632

Love, Leon (THE VIEWBOX) 40; 132; 245; 341; 502; 593

## M

MacPharland, Clarence, jt. author. See Kassel, Wayne M.

MALPRACTICE, The doctor as a target in (SPECIAL ARTICLE) (Wing) 162

"Management of the patient with terminal illness" (Breed) 503

MATERNAL MORTALITY in Chicago (1956-1968), Teenage (Lane and Brown) 241, 337

MECO Project, Expansion of a local effort, The (SPECIAL ARTICLE) (Fischer) 155

"Medical assistant must maintain perfection" (ILLINOIS MEDICAL ASSISTANTS ASSOCIATION) (Jackson) 92

MEDICAL CARE, hmo or fmc? Drastic changes ahead in (SPECIAL ARTICLE) 53

MEDICAL EDUCATION. "Doctors of the people, by the people, for the people" (SPECIAL ARTICLE) (Daugirdas) 346

"Medical Gobbledygook and Writer's Gookledygobb" (SPECIAL ARTICLE) (DeBakey) 614

MEDICAL LEGAL REVIEW (Pfeifer): 71; 167; 273;

### MEDICAL PROGRESS

"The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease" (Parts I & II) (Blonsky) 144, 250

"Drug therapy in alcoholism" (Oge) 606

MEDICINE, The "art" of (SPECIAL ARTICLE) (Breed) 159

MEGACOLON, Toxic (SURGICAL GRAND ROUNDS) (Beal, ed.) 41

MEMBERSHIP FORUM: 48; 128; 236; 613

MENINGITIS, Monitoring of Intrathecal Polymyxin B Dosage during treatment of pseudomonas (Furey, Ciric and Parker) 507

"Monitoring of Intrathecal Polymyxin B Dosage during treatment of pseudomonas meningitis" (Furey, Ciric and Parker) 507

MORTALITY in Chicago (1956-1968), Teenage maternal (Lane and Brown) 241, 337

## N

Nathan, Lester A., "Clinical experience with a new laxative in children" 598

Neiman, Ben H., jt. author. See Lee, Bak Moo.

Nelson, Kenrad E., Kallick, Charles A., and Levin, Stuart, "Diphtheria in Chicago, 1960-1970" 35

Nemickas, Rimgaudas, jt. editor. See Tobin, John R.

NEW PHARMACEUTICAL SPECIALTIES (DeHaen): 74; 172; 284; 448; 521; 618

## O

OBITUARIES: 94; 125; 235; 331; 526; 577

OBSTETRICS. "Teenage maternal mortality in Chicago (1956-1968)" (Parts I & II) (Lane and Brown) 241, 337

OBSTETRICS. "Tubal pregnancy in a patient with an IUD" (DiGiulio) 131

Oge, Verdad, "Drug therapy in alcoholism" (**MEDICAL PROGRESS**) 606

OMPHALOMESENTERIC DUCT, The patent (Doscher) 493

## P

Parker, Richard H., jt. author. See Furey, Warren.

PARKINSON'S DISEASE, The role of L-DOPA in the functional rehabilitation of patients with (Parts I & II) (**MEDICAL PROGRESS**) (Blonsky) 144, 250

Peplow, Thelma, "Positive mental attitude a 'must' for us" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) 536

PERFORATED DIVERTICULUM of the colon, Carcinoma in (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 498

Pfeifer, Frank (**MEDICAL LEGAL REVIEW**) 71; 167; 273

PNEUMOCYSTIS carinii pneumonitis and dysgammaglobulinemia, Hypertension and duodenal ulcer: Associated with (Farinas and Quel) 138

POLYMYXIN B Dosage during treatment of pseudomonas meningitis, Monitoring of Intrathecal (Furey, Ciric and Parker) 507

"Positive mental attitude a 'must' for us" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) (Peplow) 536

**PRACTICE MANAGEMENT** (Revenaugh): 70; 190; 274, 450; 556; 631

PREGNANCY in a patient with an IUD, Tubal (DiGiulio) 131

PROGRAM, Annual Convention 418

PSEUDOMONAS meningitis, Monitoring of Intrathecal Polymyxin B Dosage during treatment of (Furey, Ciric and Parker) 507

PSORIASIS, A new approach to the management of refractory (Yarbro and Leavell) 152

**PUBLIC AFFAIRS:** 72; 182; 45

## Q

Quel, Jorge A., jt. author. See Farinas, Enrico T.

## R

"Recurrent duct stones" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 342

REFLUX, Vesicoureteral (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 594

REFRACTORY PSORIASIS, A new approach to the management of (Yarbro and Leavell) 152

REHABILITATION of patients with Parkinson's Disease, The role of L-DOPA in the functional (Parts I & II) (**MEDICAL PROGRESS**) (Blonsky) 144, 250

Revenaugh, Robert P., (**PRACTICE MANAGEMENT**) 70; 190; 274; 450; 556; 631

## S

Scanlon, Patrick, jt. editor. See Tobin, John R.

**SOCIO-ECONOMIC NEWS** (Lotharius) 83; 180; 271; 439; 541; 632

STATEWIDE SYSTEM of trauma facilities, The critically injured patient: A plan for the organization of a (**SPECIAL ARTICLE**) (Flashner and Boyd) 256

SUPERIOR MESENTERIC ARTERY, Dissecting aneurysm of (Lee and Neiman) 589

**SURGICAL GRAND ROUNDS** (Beal, ed.)

"Toxic Megacolon" 41

"Hydronephrosis" 134

"Dissecting thoracic aneurysm" 246

"Recurrent duct stones" 342

"Carcinoma in perforated diverticulum of the colon" 498

"Vesicoureteral reflux" 594

Sutton, George C., jt. author. See Kassel, Wayne M.

SYNDROME, Gardner's, (Aleem) 511

## T

TECHNICAL EXHIBITS, Annual Convention 428

"Teenage maternal mortality in Chicago (1956-1968) (Lane and Brown) 241, 337

TERMINAL ILLNESS, Management of the patient with (Breed) 503

"The 'art' of medicine" (**SPECIAL ARTICLE**) (Breed) 159

"The critically injured patient: A plan for the organization of a statewide system of trauma facilities" (**SPECIAL ARTICLE**) (Flashner and Boyd) 256

"The doctor as a target in malpractice" (**SPECIAL ARTICLE**) (Wing) 162

**THE DOCTORS LIBRARY:** 49; 160; 290; 449; 524; 611

"The hypochondriacal patient in the physician's office" (Cowen) 66

"The patent omphalomesenteric duct" (Doscher) 493

**THE PEER REVIEWER:** 433

**THE PRESIDENTS PAGE:** (Breed and Fruin) 26; 115; 233; 317; 474; 582

"The role of L-DOPA in the functional rehabilitation of patients with Parkinson's Disease" (Parts I & II) (**MEDICAL PROGRESS**) (Blonsky) 144, 250

**THE VIEW BOX** (Love): 40; 132; 245; 341; 502; 593

THERAPY in alcoholism, Drug (**MEDICAL PROGRESS**) (Oge) 606

THORACIC ANEURYSM, Dissecting (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 246



Tobin, John R., Nemickas, Rimgaudas, and Scanlon, Patrick (**EKG OF THE MONTH**) 47: 143; 286; 447; 497; 605

"Toxic megacolon" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 41

TRAUMA facilities, The critically injured patient: A plan for the organization of a statewide system of (**SPECIAL ARTICLE**) (Flashner and Boyd) 256

"Tubal pregnancy in a patient with an IUD" (DiGiulio) 131

## U

ULCER: Associated with pneumocystis carinii pneumonia and dysgammaglobulinemia, Hypertension and duodenal (Farinas and Quel) 138

## V

"Vesicoureteral reflux" (**SURGICAL GRAND ROUNDS**) (Beal, ed.) 594

## W

**WHAT GOES ON:** 87; 174; 279; 445; 545; 643

"Why belong to a professional organization" (**ILLINOIS MEDICAL ASSISTANTS ASSOCIATION**) (Berschinski) 636

Wing, Herman, "The doctor as a target in malpractice" (**SPECIAL ARTICLE**) 162

WRITER's Gookledygobb, Medical Gobbledygook and (DeBakey) 614

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# A correction for the May *IMJ*

We have been informed by the Bureau of Narcotics and Dangerous Drugs of a slight mis-statement in the May, *Illinois Medical Journal*. On page 553, in the article treating the Controlled Substances Act of 1970, subtitle "Restriction Classification" it is *not correct* that any practitioner dispensing drugs must also file form 225B. A physician who obtained a new BNDD number via filing of form 224A is entitled to dispense drugs. Form 225B is for the manufacturer, distributor or researcher and is not applicable to the average practicing physician unless he is engaged in manufacturing, production or research.



# practice management

## *The "communication gap" between you and your staff*

BY ROBERT P. REVENAUGH/PROFESSIONAL BUSINESS MANAGEMENT, INC.

Working exclusively for doctors on problems concerning the business side of practice, I have learned to expect one huge gap—the communication gap between doctors and their staffs. Unlike the mendicant who wants a dime, all your staff wishes is a little time. Of course the time you spend with them represents time you don't otherwise spend with patients and therefore represents certainly more than a dime to you. But, the time you spend in communicating with your staff also represents an investment in your practice.

In previous articles we have discussed systems for maximizing tax deductions. We stressed the importance of telling your bookkeeper the nature of each transaction. In discussing your appointment systems we suggested you teach your receptionist how she should schedule appointments. I wrote about paramedical duties an aide might perform but suggested she be well instructed in performing them. We have discussed collecting information for insurance forms and effecting good credit policies. All of these topics and most others in medical practice management require as a good foundation proper communications between a doctor and his staff.

Aside from the day to day communications with your staff, which usually involves patient concerns, I feel a doctor should communicate with his staff in a minimum of three other ways.

Every medical office should have a written office manual covering at least the following topics:

1. Employee policies (vacations, pay, sick leave, bonuses)
2. Employee conduct
3. Employee responsibilities and duties
4. Personal appearance on the job
5. What to do in an emergency

6. Procedure for bookkeeping appointments
7. Telephone techniques
8. Credit policies
9. Forms used in the office
10. Maintaining medical and financial records
11. Collection procedures
12. Fee schedules
13. Keeping the confidences of patients
14. Calendar of important dates
15. Supplies—medical and secretarial

At least once each year—on a formalized basis—a doctor should have a performance review with each of his employees. During this review he should compliment the employee on the specific good points of her performance; he should also mention a few areas in which he feels the employee might improve herself. The doctor has the satisfaction of knowing how well he is doing from the response of his patients. His aide needs some indicator. The doctor is the indicator in his annual performance review with his aide.

The last minimum communications area we will discuss is a monthly meeting of the doctor and his staff. The more people involved, the more important monthly staff conferences become. These meetings usually occur over lunch time in the office. In these meetings the doctor should elicit from his staff the problems the aides have—ways of streamlining procedures, or ways in which the aides may better cooperate to make the work easier. Through this method of communications the doctor is obtaining "feed back." He is also getting invaluable ideas for a more efficient practice from the people who know, and from the people who will make the ideas a constructive change in his practice administration.

Can you spare a dime? No. Can you spare one hundred dollars worth of time? You can't afford not to. It will be the best investment you ever made.





# socio-economic news

a service of the division of health care delivery

BY JOSEPH J. LOTHARIUS

## **ISMS Delegates Approve a statewide FMC**

ISMS Delegates gave almost unanimous approval to establishing a Foundation for Medical Care in Illinois. The Delegates voiced their support for the FMC concept at a special session of the House held on May 15, one day before the opening of the annual convention. Nearly three hours of discussion were given to the FMC issue during which time more than 50 Delegates expressed their views.

Delegates asked that start-up funds for the Illinois FMC be furnished by the ISMS Board of Trustees as a loan from available non-governmental sources. It is estimated that \$30,000 will be required to complete the initial phase of the FMC's development.

\*\*\*\*\*

## **DVR fee payments Increase 10%**

A 10% (average) increase in fee payments to physicians was announced by the Illinois Division of Vocational Rehabilitation (DVR). Mr. Alfred Slicer, DVR director, told ISMS the new payment plan, which became effective April 1, would reach the usual charges of 70% of the physicians in Illinois. Mr. Slicer said that "like the recent Medicare increases, the updating of fee profiles is applicable to those physicians who increased their charges in 1969, but who bill within the limits of 70% of the physicians in their area." Slicer had asked ISMS endorsement for the new payment proposal. ISMS Trustees did not endorse the proposal, however, because it failed to fully meet the usual, customary and reasonable fee criteria established by the House of Delegates.

\*\*\*\*\*

## **Surgeon fees Should include Some post-operative care**

Post-operative care while in the hospital should be included in the surgical fees, according to ISMS. However, the Board said that following dismissal from the hospital, fees for post-operative care should be paid according to the usual and customary practices within the community.

## **Adams County MDs opposed To hospital-based plans**

Adams County physicians report there are no plans to form a hospital-based closed panel program in Quincy. The possibility that such plans were being considered was reported in the April issue of *Illinois Medical Journal*. Dr. Lucius Hollister, president of the Adams County Medical Society, said he was unable to find any basis for such rumors. "I have also taken a poll sampling of our members and find unanimous objection to any kind of hospital based closed panel program," he said.

---

## ***Wine and health communications contest announced***

A new contest which recognizes outstanding communications about wine and health has just been announced.

One thousand dollar prizes will be awarded in three categories for works which tell of the health aspects of wine, and appeared during the fiscal year extending from July 1, 1970 to June 30, 1971.

Three eminent medical editors will judge the entries. They are: Theodore Van Dellen, M.D., syndicated columnist and editor of the *IMJ*; Charles G. Roland, M.D., chairman, Department

of Biomedical Communications, Mayo Clinic, and president of the American Medical Writers Association; and Byron T. Scott, editor of *Today's Health* magazine, published by the AMA.

Prizes will be awarded for articles published in public newspapers and magazines, medical publications and for radio-television broadcasts.

The deadline for entries is July 31, 1971.

Details of the contest are available from the Administrator, Wine & Health Writing Awards, Suite 1307, 703 Market St., San Francisco, Calif. 94103.

## ***MEDCOM announces . . . "Poison in the walls"***

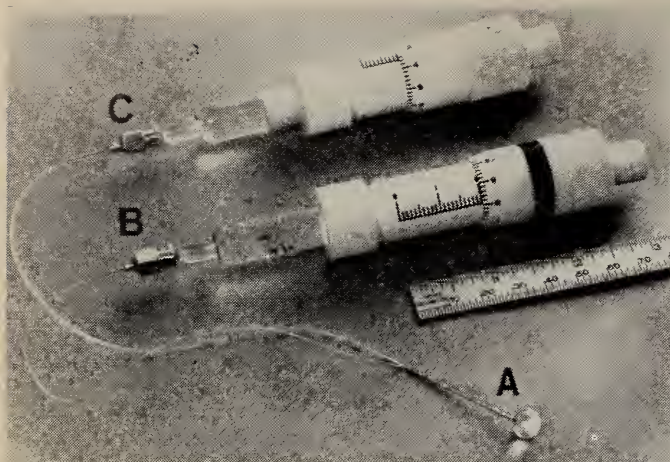
A new audio-visual program produced by MEDCOM, Inc., in cooperation with the American Academy of Pediatrics, is now available for use in health centers, community centers, hospitals, and schools. Entitled "Poison in the Walls," the program concerns the prevention and detection of lead poisoning.

"Poison in the Walls" was photographed in color on location in New York City using several residents of hazardous old buildings as actors. The film follows a child through the causes, symptoms, tests and

treatment for lead poisoning. Adults learn how to deal with the dangers of lead-based walls and ceilings as well as other lead-dangerous articles. And parents are taught how to take advantage of available public health units established to screen potential lead poisoning cases.

The program is available in three convenient formats, utilizing filmstrip and record, filmstrip and cassette or 35mm slide and record. Both English and Spanish soundtracks are provided, and take-home materials are supplied in both languages.





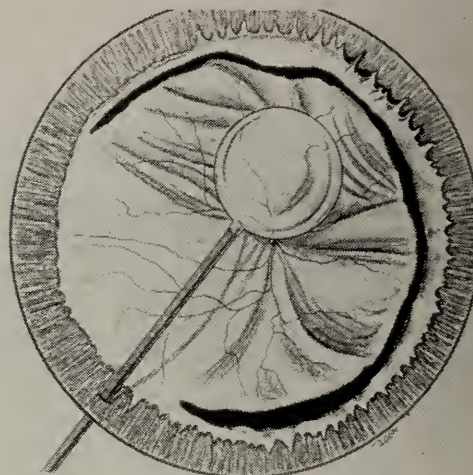
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## *Inflatable balloon developed for eye surgery*

In one of the most unusual assignments ever received, Firestone, through its Permalastic Products division, was able to help a surgeon restore the sight of several persons suffering from severe cases of retina detachment.

The device is known as an intraocular balloon which has already been useful in desperate cases of retina detachment with giant retinal tears. The balloon is used to unfold a retinal flap and move it back into its normal position where it can be "welded" into position.

The balloon is made of latex rubber, molded over a flexible double-barreled surgical tube with a spherical tip. The uninflated tip is only 1.5 millimeters in diameter (less than one-sixteenth of an inch). The balloon can be inflated to a diameter of 10 millimeters. The instrument is connected by plastic tubing to two micro-syringes. One is used for inflation and deflation

of the balloon. The other injects saline or air into the eye to replace the space occupied by the balloon as it is deflated.

The instrument has been used in about 18 desperate cases and in a third of these cases useful vision has resulted.

The tiny inflatable intraocular balloon, made of rubber latex, is inserted into the eye with extreme care and then inflated. Long research showed that such gentle contact with the balloon was not damaging to the fragile retina, but it did permit the breaking of the adhesions of the folded over portions. The balloon, as inflated, prods the detached retina back into place against its natural bed, the choroid layer. It is held in place until "spot welding" can be performed. This welding creates scar tissue to hold the retina in place permanently.



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*Physical and Psychological Dependence:* Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

*Usage in Pregnancy:* Weigh potential benefits in pregnancy, during lactation, or in women of child-bearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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## report

a service of the illinois medical assistants association

### *Why belong to a professional organization?*

BY JEAN BERSCHINSKI/COOK COUNTY SOUTH

Parents belong to the P.T.A. if their children are concerned; "Little League" if their boys are involved; Scouting, if their children are interested; and men and women to many civic organizations. But why belong to a professional organization?

For Medical Assistants the answers are simple. First, to better serve the doctors for whom we work and second, to better serve the patients who come to our doctors. I.M.A.A. helps us in our offices, hospitals and other health care institutions. It offers programs, meetings, workshops and conventions to discuss and consider ways to improve and make our places of employment move more efficiently. It is not a union or bartering agent.

We are approved and supported by the AMA on the national level, the ISMS on the state level, and by the local medical society on the county level; we are the only organization supported in this manner.

Those of us who have been in the profession for many years have expressed our dedication and can never stop studying. Our organization is geared to help us by providing the tools and techniques to also improve our working ability and performance.

We realize that professionalism means an ever-changing body of knowledge that must expand constantly with the changes in our times and in medicine, and in the care of sick patients.

Again, this is where our organization can help us learn significant changes and keep us up with the times.

Personal sacrifice is needed to join and maintain active membership in any organization, but the time involved is given back two-fold when we can better handle the demands put upon our doctors and us, by the public, through good waiting room technique, proper execution of medical forms, fast transcription of records and all other phases of the problems we meet daily. There is no easy way out; we must have a good defense through education to handle the problems we face.

Another advantage is making firm and lasting friendships with people working in our field. Our organizational work provides an opportunity to make many good friends and to meet others from all over the United States, including Hawaii and Alaska. Our local meetings are held near our work or homes.

You have read our reasons for membership in a professional organization. Our dues are slight in comparison to the benefits we can attain. Let's make our profession stronger. Join the over 500 women in Illinois and help your doctor, your patients and yourself.

For further information contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Illinois, 60451 or Mrs. Vivian Kraft, R.R.#2, Normal, Illinois, 61761.

---

#### **How built-in spending has grown**

So much federal spending is tied to built-in features that only one-third of the proposed 1972 budget requires Congressional approval. The remainder is automatically allocated for programs or commitments from previous years, or to pay the interest on the nearly \$400 billion debt.

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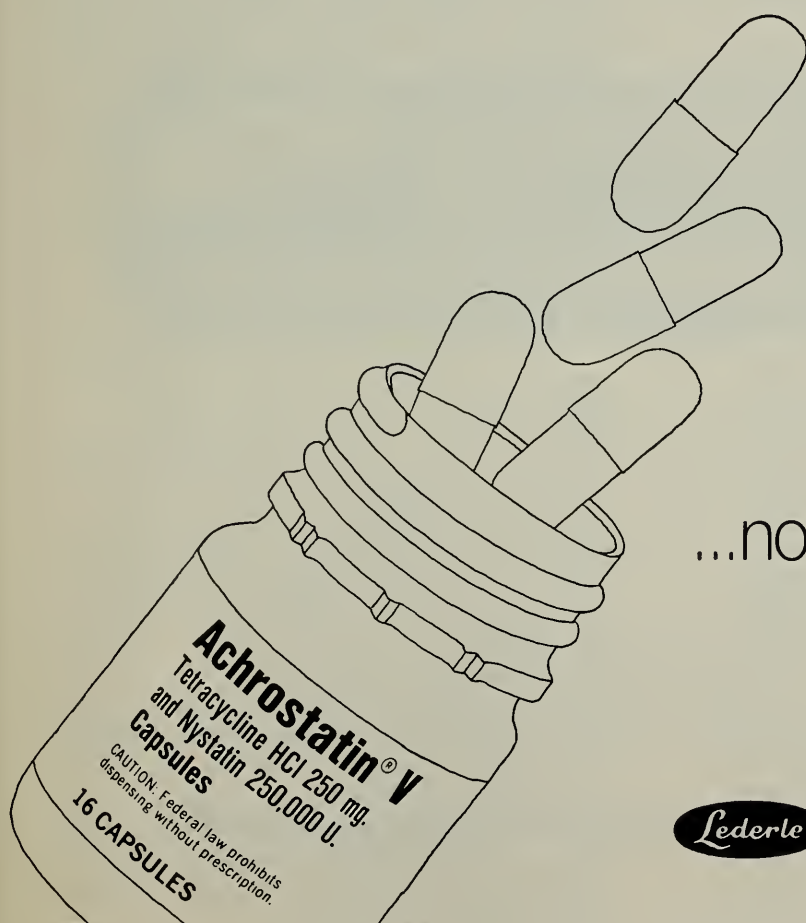
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# Dissecting aneurysm ...

(Continued from page 592)

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## COOK COUNTY Graduate School of Medicine

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SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Oct. 4  
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ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 12  
SURGERY OF THE HAND, Three Days, September 15  
PEDIATRIC SURGERY, One Week, September 27  
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 25  
VAGINAL APPROACH TO PELVIC SURGERY, One Week, July 19  
ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Oct. 11  
CLINICAL ENDOCRINOLOGY, One Week, June 14  
REVIEW COURSE IN RHEUMATOLOGY, One Week, June 28  
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# the presidents page

(Continued from page 582)

April 25—Executive Committee (10 people, 6 hours)

April 26-28—ISMS Washington Round-Up (44 people, 3 days)

April 27—ISMS Foundation presentation to the 7th District in Vandalia (17 people, 2½ hours)

April 28—ISMS Foundation presentation to the 9th District in Mt. Vernon (17 people, 3 hours)

April 28—Council on Economics and Peer Review (17 people, 3 hours)

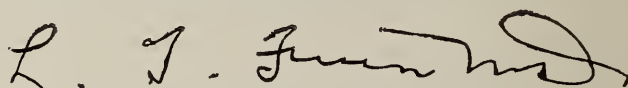
Just reviewing this doesn't really say much more than a lot of people got together on certain days. Did they accomplish anything? This is the essence of their being! These formal meetings represent from one to ten hours of "homework" for the physicians and staff members involved and frequently the same amount of time and effort afterwards to implement or consum-

mate the decisions and/or opinions reached.

In this short column it would be impossible to relate all the decisions made and directions taken in furthering the cause of medicine and in the protection of the public's well-being. But rest assured, the actions taken have been or will be implemented by legislative action, letters to appropriate agencies or persons, or actual legwork by committee members.

While the benefits of any specific action may not accrue to each member in a tangible aspect, these activities together redound to the good of ISMS and the people of Illinois and this in turn enhances the value of membership.

In this, my first President's Page, I hope I have made some points for you to ponder. In future issues I will bring other thoughts to you about my impressions of activities or further items for your cogitation.



## the viewbox

(Continued from page 593)

**DIAGNOSIS:** Recurrent carcinoma with lymph node metastases. This case is interesting because of the unusual demonstration of the uretero-pelvic obstruction in a recurrent carcinoma of the cervix. The usual sequence of events is direct extension into the parametria with gradual obstruction of the distal portion of the ureter rather than the proximal portion at the uretero-pelvic junction. The differential diagnosis in this case was eliminated with the observation of bone destruction of the right pelvic inlet where the sharp, dense border of the pelvic brim is no longer demonstrated (Fig. 1)—just lateral to the sacro-iliac joint and extending down the proximal portion of the pelvic brim. It was felt that this represented direct invasion of bone at this site and that undoubtedly the uretero-pelvic obstruction was the result of lymph node extension up the para-aortic chain. This is a very rare occurrence in carcinoma of the cervix, where extension is usually direct. An attempt at palliative surgery to relieve the uretero-pelvic obstruction revealed the findings of large lymph nodes extending up the para-aortic chain with histology of squamous cell carcinoma.

## ekg of the month

(Continued from page 605)

**ANSWERS** (1, 3, 4 and 5):

1. The diagnosis of left ventricular hypertrophy is supported by voltage criteria. Although the standardization should have been reduced to one half ( $1 \text{ mv} = 5 \text{ mm}$ ) for precise recording, the sum of the amplitudes of  $SV_1$  and  $RV_6$  is greater than 35 mm. Other criteria for LVH present include delayed intrinsicoid deflection (0.05 sec in  $V_6$ ).
3. A palpable point of maximum impulse (PMI) of sustained (prolonged) character, particularly if associated with a parasternal dip, is invariably associated with concentric hypertrophy of the left ventricle, i.e., out-flow tract stenosis or systemic hypertension.
4. The ESEC, the ejection systolic murmur, and the early diastolic decrescendo blowing murmur suggest dominant aortic stenosis with mild aortic insufficiency.
5. A pulsus bisferiens is a double peaked pulse in systole, i.e. prior to the aortic notch, palpable in the carotid artery and commonly associated with combined aortic stenosis and insufficiency.

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# what goes on

## a guide to continuing education

### June 21-July 2—Alfred Adler Institute

#### *Workshops on the Practical Application of Adlerian Psychology*

*Workshop II* (June 21-25): Understanding Oneself Biased Apperception and Private Logic; The Fallacy of Inner Conflicts: The Function of Emotions; The Difficulty of Recognizing Self-Determination and Equality; The Fallacy of Inferiority Feelings; Development of Social Interest; and How to Deal with Oneself.

*Workshop III* (June 28-July 2): Practicum in Counseling and Psychotherapy Case presentations of family counseling, marital counseling, individual and group psychotherapy, with active participation of advance students.

Contact for additional information and registration: Alfred Adler Institute, 110 S. Dearborn St., Chicago 60603.

### June 23-26—National Paraplegia Foundation 1971 Convention

The purpose of the convention is to provide information about care, cure and potential of those with spinal cord injuries to members of associated health professions, such as nurses, therapists, counselors and physicians and scientists engaged in cure and care of those with spinal cord injury.

*Special Events:* Medical Scientific Seminar; Associated Health Professions Training Program; Community Action Workshops; and Exhibits  
Henry B. Betts, M.D., professor and chairman, Department of Rehabilitation Medicine, Northwestern University, McGaw Medical Center and Medical Director, Rehabilitation Institute of Chicago, is director. Moderators are: Paul C. Bucy, professor of neurosurgery, and Charles E. Caniff.

Hillside Holiday Inn, Hillside, Illinois

### July 12-14—American Academy of Pediatrics

#### *Postgraduate Course on Chronic Diseases of Childhood*

Specific clinical topics will be covered by subspecialties in hematology, allergy, rheumatology, clinical immunology, chest diseases and anesthesiology. Other clinical topics to be discussed include: psychiatry, genetics, renology, radiology, endocrinology and gastroenterology.

An attempt will be made to present material pertinent to everyday practice.

For additional information contact: Gerald E. Hughes, M.D., director, Department of Educational Affairs, American Academy of Pediatrics, P.O. Box 1034, Evanston 60204.

### July 12-23—Massachusetts Institute of Technology

#### *Design and Analysis of Scientific Experiments*

Two week summer program for persons interested in planning, analysis, and evaluation of economical and effective experiments in physical, chemical, biological, medical, engineering or industrial sciences.

For particulars write: Director of Summer Session, Room E19-356, Massachusetts Institute of Technology, Cambridge, Mass. 02139.

### July 16-17—UCLA Residential Conference Center

#### *Course in Scientific Communication*

UCLA Residential Conference Center, Lake Arrowhead. Fee: \$225.

For information write: Continuing Education in Medicine and Health Sciences, Room 15-39 Rehabilitation Center, West Medical Campus, University of California, Los Angeles, Calif., 90024, or telephone Mrs. Elizabeth Gifford at (213) 825-7186.

### July 16-17—Rocky Mountain Cancer Conference

#### *Cancer of the Head and Neck and the Newest in Chemotherapy*

Co-sponsored by American Cancer Society, Colorado Div. and Colorado Medical Society. Richard Jesse, M.D., Robert D. Lindberg, M.D., Robert W. McDivitt, M.D., Dr. R. Wayne Ruddles. For information write: Rocky Mountain Cancer Conference, 1764 Gilpin Street, Denver, Colo. 80218.

### July 17—American Association of Medical Clinics

#### *North Central Regional Meeting*

Holiday Inn, LaCrosse, Wisconsin

### July 18-August 8—Diabetes Association of Greater Chicago

#### *Summer Camp for Diabetic Children*

Boys and girls ages 8-13 are eligible. For applications and inquiries write: Diabetes Association of Greater Chicago, 620 North Michigan Avenue, Chicago, Ill. 60611 or call, (312) 943-8668.



**July 31-August 1—Continuing Education of  
the Bar and Medical-Legal Society of  
Southern California**

*National Conference on Medical Malpractice  
and Doctor-Lawyer Relationships*

Panels of doctors and lawyers will discuss the prevention and the defense of medical malpractice suits,

insurance coverage, and possible alternatives to the present system of malpractice litigation.

Overall objective of the conference is to promote better understanding between the two professions.

For further information write: California Continuing Education of the Bar, 2150 Shattuck Ave., Berkeley, Calif. 94705.

University of California Extension, Berkeley, Calif.

*(Save for reference)*

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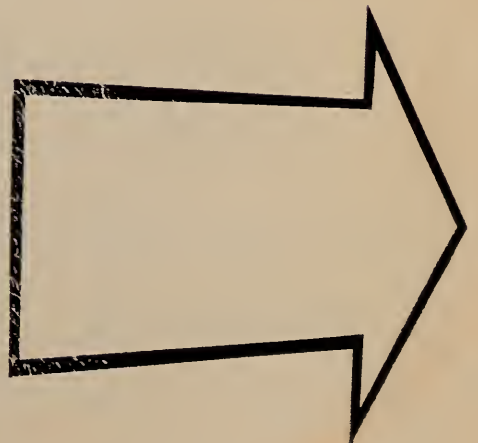
## **Emotional fitness and the practicing physician**

Provisions for a physician's mental illness should be part of the laws of all states. Since 1960, when the last survey was conducted, twelve more states have included mental illness specifically in their medical practice laws and thirteen states have reported laws already in existence. Automatic suspension of committed cases should be available for all state boards. Many states already have such a provision in that the majority of states favor suspension over revocation as a first step. Too few states have a policy for assisting in the rehabilitation of the mentally ill physician or for providing probation and control. Twenty-eight states indicated they have no policy of assistance for the mentally ill physician. While the opinions were quite divergent among the various states as to how to deal with the mentally ill physician, the measures receiving the most emphasis were utilization of psychiatric examinations and reports, appropriate measures for suspension and revocation of license, the need for the follow-up and probation authority, and better communication between the board and the hospital, psychiatrist, physicians and families.

It is my recommendation that perhaps what is needed is a nonjudgmental "board of professionalism," which would be involved in cases of incompetence and operating in complete confidentiality. A start in this direction has already been made by the San Francisco Medical Society. Such a board's function would be to evaluate each case brought to its attention from the point of view of offering suggestions and assisting the individual physician in obtaining whatever help might be needed in terms of treatment and rehabilitation.

Once again, it is important to emphasize that it would be the function of such a board to formulate an overview of the multiple factors involved and to make specific recommendations regarding management and possibilities for rehabilitation—and not to determine incompetence which is a judicial function. I would like to restate the need for enlightened concern for the problem of medical incompetence and the broader problems of mental illness in physicians. Every physician has worked hard and suffered much to achieve his vocational goal. It is the moral obligation of the profession to regard the physician who falters because of human frailty with compassion and not scorn. His rehabilitation must be our concern. (John C. Duffy.: **Emotional Issues in the Lives of Physicians.** Charles C. Thomas, Springfield, Ill. 1970.)

**Please turn page  
to help the *IMJ***





**DOCTOR, Please be our CONSULTANT:**

Your responses to the questions below will be helpful in shaping the contents of the *IMJ*.

The clinical articles below can be found in this June issue:

1. "*Dissecting aneurysm of superior mesenteric artery*"  
Bak Moo Lee, M.D., and Ben H. Neiman, M.D.
2. "*Clinical experience with a new laxative in children*"  
Lester A. Nathan, M.D.
3. "*Drug therapy in alcoholism*"  
Verdad Oge, M.D.
4. "*Disseminated Chlamydial infection*"  
Wayne M. Kassel, M.D., George C. Sutton, M.D., Clarence MacPharland, M.D., and C. Laurence Etheridge, M.D.
5. "*Vesicoureteral reflux*" *SURGICAL GRAND ROUNDS*

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**PLEASE MARK THE ONE ARTICLE YOU FOUND MOST INTERESTING:**

Please circle the number of the article you found most interesting in this issue:

1      2      3      4      5

Controls:

For how many years have you been a physician? .....

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(If group:) How many including yourself? .....

Is your practice    (    ) urban,    (    ) suburban or    (    ) rural? ....

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